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THE WEST VIRGINIA

# Medical Journal

OFFICIAL ORGAN OF THE WEST VIRGINIA STATE MEDICAL ASSOCIATION

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VOL. 56, NO. 1 JANUARY, 1960

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*August 25-27, 1960*

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CELONTIN kapseals (methsuximide, Parke-Davis) 0.3 Gm., bottles of 100.

**bibliography:** (1) Green, J. R., & Steelmon, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, p. 136. (2) Bray, P. F.: *Pediatrics* **23**:151, 1959. (3) Davidson, D. T., Jr., in Conn, H. F.: Current Therapy 1959, Philadelphia, W. B. Saunders Company, 1959, p. 512. (4) Smith, B., & Forster, F. M.: *Neurology* **4**:137, 1954. (5) Zimmerman, F. T.: *New York J. Med.* **55**:2338, 1955. (6) Lemere, F.: *Northwest Med.* **53**:482, 1954. (7) Perlstein, M. A.: *Pediat. Clin. North America*: **4**:1079 (Nov.) 1957. (8) Livingston, S., & Pauli, L.: *Pediatrics* **19**:614, 1957. (9) Carter, C. H., & Maley, M. C.: *Neurology* **7**:483, 1957. (10) Keith, H. M., & Rushton, J. G.: *Proc. Staff Meet. Mayo Clin.* **33**:105, 1958.

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JANUARY
1960

Vol. 56 No. 1

# The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.

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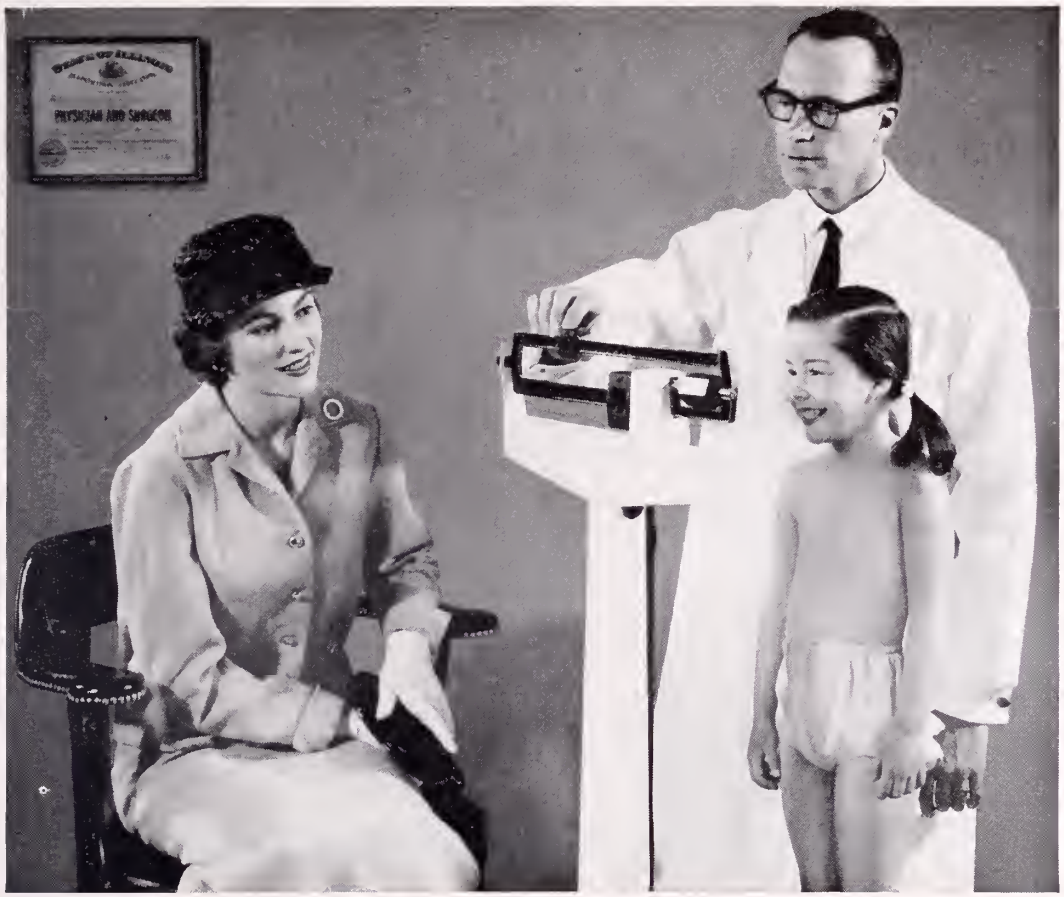

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Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

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---

*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

# WVU Medical Center
# —News—

A special program honoring the retiring dean of the West Virginia University School of Medicine, Dr. Edward J. Van Liere, has been arranged for May 12 at the Medical Center in Morgantown. Doctor Van Liere has been associated with the University for nearly 40 years and has served as Dean of the School of Medicine since 1935. He will continue to serve on the faculty as Professor of Physiology.

The committee in charge of arrangements has announced that there will be a scientific session in the afternoon, with papers to be presented by two prominent physiologists of Doctor Van Liere's acquaintance.

Later in the afternoon, a portrait of Doctor Van Liere will be unveiled. It will be displayed permanently in the Medical Center.

A banquet will be held that evening, at which time associates of Doctor Van Liere's through the years will have the opportunity to voice an appreciation.

### Seminar on Space Medicine

A Seminar on Space Medicine was presented at the Medical Center on November 20. The guest speaker was Commander Arthur L. Hall, MSC, USN, who discussed the medical aspects of putting a man safely into space.

Commander Hall, who was assisted by two enlisted Navy personnel, discussed results of a recent test in which a flight surgeon was exposed to space conditions for 72 hours. He also displayed the type of space suit used during the simulated flight into space.

Lt. Richard H. Tabor, MC, USN, a native of Welch, West Virginia, was chosen for the experiment in which he spent 72 hours in a low pressure chamber.

Doctor Tabor was selected for the experiment because he embodied the ideal characteristics for a space pilot, according to Doctor Hall. His medical training coupled with his jet flying experience helped him to answer many questions from his trained observations as the tests progressed.

Doctor Tabor attended Greenbrier Military School and was graduated from the two-year WVU School of Medicine in 1950. He received his M. D. degree from the University of Cincinnati College of Medicine in 1952.

Doctor Hall stated that results of the test proved (1) That man can tolerate these conditions for periods up to 72 hours, (2) That the Navy Mark III Model II full-pressure suit is tolerable at extremely high altitudes for extended time intervals, and (3) That man can function adequately under space conditions with negligible physiological psychological deterioration.

• **Compiled from material furnished by John B. Harley, M. D., Assistant Professor of Pathology and Public Information Officer at the WVU Medical Center in Morgantown, W. Va.**

### Research Grants

Dr. R. F. Krause, professor and head of the Department of Biochemistry, has received a $3,950 research grant from the United States Atomic Energy Commission to support research on "Degradation Studies on C14-labeled Carotene."

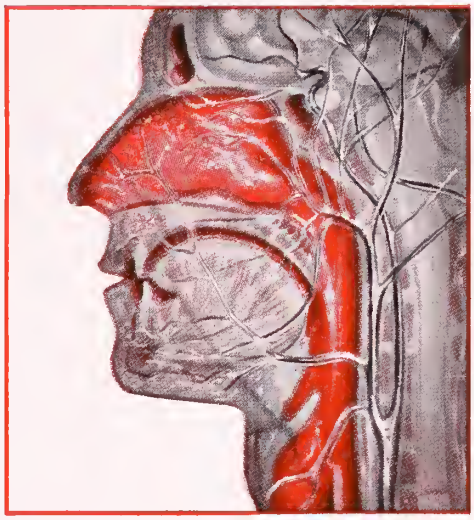
The grant, fifth renewal of one which began originally in 1954, will be used by Doctor Krause, together with Dr. Frederick J. Lotspeich, associate professor of biochemistry, to continue their research work on the metabolism of Beta Carotene.

Dr. Kenneth E. Penrod, Vice President-Medical Affairs, WVU Medical Center, has been awarded a $5,000 unrestricted grant by the Smith, Kline and French Laboratories.

The grant will be used to help staff the clinical departments of the School of Medicine and the Teaching Hospitals in ways which might be more difficult through routine channels.

**Commander Arthur L. Hall, MSC, USN, left, was the guest speaker at a seminar which was held at the WVU Medical Center on November 20. Shown with Commander Hall are Dr. Edward J. Van Liere, Dean of the School of Medicine, center, and Dr. John B. Harley, Assistant Professor of Pathology.**

# reaches all nasal and paranasal membranes *systemically*[1]



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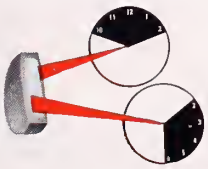

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1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

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# The Month in Washington

• From the Washington Office of the American Medical Association

CONGRESS embarked on a crucial election year session with expansion of the Social Security program shaping up as one of the major issues. It was virtually a foregone conclusion that some liberalization of the program would be voted in the Democratic-controlled Congress, but the key question was how far the changes would go. In every Presidential election year during recent years, the House and Senate have approved a broadening of the program.

### Election Year 'Favorite'

One of the prime reasons Social Security has been an election year "favorite" is that the program can be boosted without affecting the Federal budget. This is because it is financed through employer-employe contributions and is theoretically self-supporting.

Of special interest to physicians, of course, is the fate of the so-called Forand Bill that would provide hospitalization, surgical services, and nursing home care for Social Security beneficiaries. This would be accomplished through even higher taxes on employes and employers than now scheduled through already-voted step increases.

Supporters of the controversial legislation—vigorously opposed by the Administration, the American Medical Association, and allied organizations—launched their move to win enactment this session.

### Social Security Program

Sen. Pat McNamara, (D., Mich.), whose Senate Subcommittee on Aging held a series of hearings across the country during the recess, announced at the conclusion of the hearings that they showed a need for expanding Social Security to include health care for the aged. He indicated he thought the Forand Bill did not go far enough.

A battery of speakers at a meeting here of the American Public Welfare Association also urged a sharp increase in benefits, with some advocating "cradle to grave" security for all.

Not all of the proposals for extending the program involved health care.

The Administration indicated it would recommend some expansion, especially in the disability program under which the Federal Government helps the states provide assistance to persons over age 50 judged to be totally and permanently disabled. An influential lawmaker, Rep. Burr Harrison (D., Va.), disclosed that he would introduce legislation to remove the age 50 limitation to allow all persons regardless of age to participate. He estimated this would not require any hiking of the taxes. Rep. Harrison is Chairman of a House Ways and Means Subcommittee that held recess hearings on administration of the disability program.

Meanwhile, Chairman Wilbur Mills (D., Ark.) of the full Ways and Means Committee cleared the way for full-scale hearings this Congressional session on the entire issue of Social Security. In listing specific phases to be considered, however, the lawmaker did not mention the Forand proposal.

### Miscellaneous

A spokesman for the American Medical Association told the Federal Communications Commission that the AMA believes the best solution to objectionable advertising and programs on television and radio is for the industry "to clean its own house."

Dr. Eugene F. Huffman, co-chairman of the AMA's Physician's Advisory Committee on Television, Radio and Motion Pictures, declared "the medical profession . . . stands ready to assist the networks and individual stations in determining accuracy and good taste of broadcast material involving health or medicine—either commercial or public service."

## Leisure

If the ability to use leisure intelligently is the last product of civilization, may it not be hoped that the leisure that lies ahead will see the overcrowding of libraries, the overfilling of all institutions of learning, the avid pursuit of avocations until in their perfection they become as important as vocations.

Is it not potential that leisure skillfully embraced may make of every man a philosopher? Is not leisure properly espoused that which provides the dignity that every man seeks?

Some hundreds of years ago the Roman writer Seneca made the worm the symbol of leisure when he said, "Who has more leisure than a worm?" Seneca did not know all. The lowly earthworm is nature's great irrigation engineer. The earthworm is a foremost citizen of the land. Endlessly he utilizes his total leisure. If an earthworm can do as much with his leisure, surely every workman may find opportunity to turn his earned augmented leisure to good account. —Industrial Medicine and Surgery.

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# County Societies

### BARBOUR-RANDOLPH-TUCKER

The regular monthly meeting of the Barbour-Randolph-Tucker Medical Society was held at Phil's Restaurant in Elkins on November 19. The topic for discussion was "Dental Health Services," and dentists in the area also attended the meeting.

The two speakers were Dr. John H. Shenasky and Dr. Kenneth V. Randolph, both of whom are dentists.

Doctor Shenasky discussed "Hospital Dental Services," and he stated that approximately two hundred diseases produce some dental signs. He also discussed the importance of dental care as being part of the total medical care of the patient. He cited several examples to illustrate the importance of removing a dental focus of infection.

Doctor Randolph, who is dean of the West Virginia University School of Dentistry, discussed the dental clinics which are now in operation at the WVU Medical Center. He pointed out some interesting facts concerning the distribution of patients as to age, nature of disease and other factors. He said the dental clinics had been well attended and that each dental student has had from twelve to fourteen patients.

Dr. Marion E. Ingram was unanimously elected to membership in the Society.

Dr. Paul D. Snedegar, the president, presided at the meeting which was attended by more than thirty physicians, dentists and guests.—Charles L. Leonard, M. D., Secretary.

* * * *

### CABELL

Dr. John L. Parks, Dean of George Washington University School of Medicine, was the guest speaker before the regular monthly meeting of the Cabell County Medical Society, held in the Georgian Terrace Room of the Frederick Hotel in Huntington, Nov. 12, 1959. His subject was "The Indications and Contraindications for the Induction of Labor." A question and answer period followed his address.

The following resolution of respect to the memory of Dr. Will E. Neal, who died November 12, 1959, was offered by Dr. James S. Klumpp and unanimously adopted:

> This date marks the loss to our community and the medical profession of a beloved and distinguished citizen and physician.
>
> The Divine Physician has deemed it fitting to call Will E. Neal from a world of tribulation and sorrow to a heavenly home of eternal blessedness.
>
> Will Neal practiced the art of healing in this community for half a century. He was loved and respected by the many persons to whom he had ministered.
>
> He always occupied a position of great esteem in the hearts and minds of his professional brethren, who recognized in his character and acts the marks

**Radiology:**
KARL J. MYERS, M. D.

**Clinical Pathology:**
E. E. MYERS, M. D.

**Surgery:**
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

**Gynecology and Obstetrics:**
RAYMOND W. CRONLUND, M. D.

**Internal Medicine:**
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

**Pediatrics:**
CORA C. LENOX, M. D.

**Anatomical Pathology:**
S. D. WU, M. D.

**Dentistry:**
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of a real gentleman and a dedicated man of medicine.

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Therefore, Be It Resolved, by the Cabell County Medical Society that this eulogy to a fellow physician be entered in the records of the Society, and further, that a copy of the same be transmitted to the members of his family.

Dr. Hans Werener Dransfeld was elected an active member of the Society, and Dr. Joseph Krimsky, an associate member.

The Society appropriated $150.00 for the purpose of assisting in the promotion of the Marshall College Regional Science Fair.

The president, Dr. John F. Morris, presided at the meeting, which was attended by 65 members.—Jack Leckie, M. D., Secretary.

* * * *

**FAYETTE**

Dr. Thomas C. Sims was elected president of the Fayette County Medical Society at a meeting held at the Glen Ferris Inn, at Glen Ferris, on December 2, 1959.

Other officers elected for the coming year include Dr. Raymond A. Updike, vice president, and Dr. Marvin Kirsh, secretary-treasurer. The election of delegates and alternates to the annual meeting of the State Medical Association was deferred until a later meeting.

The Society voted unanimously to contribute the total proceeds from the polio clinics to the Fayette County Medical Society Loan Fund, which is under the administration of the West Virginia University Foundation for medical students. The total amount of the Fund will be approximately $2,500.

Following the business meeting, a Grand Rounds Film, "Cardiac Stress: Work, Surgery, Pregnancy," was shown. Dr. W. B. Davis, the retiring president, presided at the meeting.—Joe N. Jarrett, M. D., Secretary.

* * * *

**HARRISON**

Dr. Richard V. Lynch, Jr., was named president of the Harrison County Medical Society at a meeting held at the Stonewall Jackson Hotel in Clarksburg on December 3.

Other new officers include Dr. Harry T. Linger, president elect, Dr. A. Robert Marks, secretary, and Robert S. Wilson, treasurer.

The Society elected the following members to the Board of Directors for the coming year: Drs. Richard V. Lynch, Jr., Andrew J. Weaver, A. Robert Marks, Harry T. Linger, Robert S. Wilson, Richard K. Hanifan and James G. Ralston.

Dr. Bernard W. Wilkinson, the retiring president, presided at the meeting which was attended by more than 25 members.—Andrew J. Weaver, M. D., Secretary.

* * * *

### MERCER

Dr. David F. Bell, Jr., of Bluefield, was the guest speaker at the regular monthly dinner meeting of the Mercer County Medical Society which was held at the Matz Hotel in Bluefield on November 16.

Doctor Bell discussed "The Surgical Pathology of Several Fungus Diseases," including blastomycosis, coccidioidomycosis, actinomycosis, histoplasmosis, as well as fungus invaders in lymphoma and chronic diseases such as mucormycosis and aspergilosis. He emphasized that many of these diseases mimic tuberculosis and are found primarily in the lungs. His paper which was illustrated by lantern slides was discussed by several members.

The following resolution of respect to the memory of Dr. V. L. Kelly, who died October 10, 1959, was offered by Dr. E. Lyle Gage and unanimously adopted:

> Whereas, Our friend and fellow physician, Virgil Lonnie Kelly has been suddenly called from this world by his Maker, and,
>
> Whereas, His fellow members of the Mercer County Medical Society greatly miss him, both at the meetings and in the daily and weekly associations with him in the care of the sick, and,
>
> Whereas, We the members of the Mercer County Medical Society wish to record our sincere sorrow at his passing and our great sympathy for his family,
>
> Therefore, Be It Resolved, That this resolution be spread on the minutes of this meeting of this Society, and that a copy be sent to his family.

Dr. Gordon L. Todd, Jr., the president, presided at the meeting and appointed the following nominating committee to select officers for 1960: Drs. L. J. Pace, Henry C. Davis, Henry F. Warden, Jr., and Upshur Higginbotham.—John J. Mahood, M. D., Secretary.

* * * *

### MONONGALIA

Dr. David Z. Morgan was elected president of the Monongalia County Medical Society at a dinner meeting held at the Hotel Morgan in Morgantown on December 1. He succeeds Dr. Robert J. Fleming.

Other new officers for the coming year are Dr. Clement A. Smith, vice president; Dr. C. A. Logue, secretary; and Dr. John H. Trotter, treasurer.

The following physicians were named as delegates to the annual meeting of the State Medical Association next August: Eldon B. Tucker, George A. Curry and J. J. Lawless. The alternate delegates are Drs. Clark K. Sleeth, Maynard P. Pride and French R. Miller.

Doctor Fleming, the retiring president, was elected a member of the Board of Censors.—C. A. Logue, M. D., Secretary.

* * * *

### OHIO

The October meeting of the Ohio County Medical Society was held at Wilson Lodge, Oglebay Park, Wheeling, with Mr. Kenneth V. Hill as the guest speaker.


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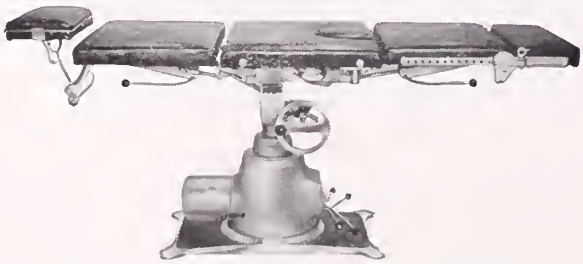

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Mr. Hill spoke most interestingly on the subject of Wheeling's new sewage disposal operation and described the Zimmerman Process, which he said was the second such process to be installed in this country.

At the business session following the program, Drs. D. A. MacGregor, R. H. Lewellyn, C. Glen McCoy and George L. Viewig, Jr., were elected to honorary membership in the Ohio County Medical Society.

Drs. Willard J. Howland, Jr., Frank N. Hudson and James A. Jacob were elected to membership in the Society.

The November meeting of the Society, also held at Wilson Lodge, Oglebay Park, was attended by 93 members and five guests.—William H. Hagedorn, Jr., Executive Secretary.


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# *Woman's Auxiliary*

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*Corresponding Secretary:* Mrs. James W. Hamilton, Marlinton
*Parliamentarian:* Mrs. J. Preston Lilly, Charleston

## CABELL

The November meeting of the Woman's Auxiliary to the Cabell County Medical Society was held in the Crystal Room of the Hotel Frederick in Huntington, with the president, Mrs. Lee F. Dobbs, presiding. The guest speaker was Mrs. Boz Johnson who spoke on the subject of "The Woman's Place in Today's World."

It was announced that Mrs. C. L. Terlizzi, a past president of the Auxiliary, is now president of the Huntington Inter-Club Council.—Mrs. M. W. McGehee, Correspondent.


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### EASTERN PANHANDLE

Mrs. John R. Heller, Jr., of Kensington, Maryland, was the guest speaker at a recent meeting of the Woman's Auxiliary to the Eastern Panhandle Medical Society, which was held at the Shenandoah Hotel in Martinsburg.

Mrs. Heller, who is the wife of the assistant surgeon general of the U. S. Public Health Service, presented an interesting talk on her travels with her husband as he represents the American people throughout the world. Doctor Heller is in charge of the Cancer Research Program of the National Institutes of Health at Bethesda, Maryland.

Prior to the meeting, a coffee was held in the home of Mrs. Curtis G. Power, the president.

Hostesses for the luncheon meeting were Mesdames John H. Kilmer, R. B. Talbott, and Roger E. Clapham.

* * * *

### HARRISON

The annual Christmas dinner of the Woman's Auxiliary to the Harrison County Medical Society was held in the Crystal Room of the Stonewall Jackson Hotel in Clarksburg on December 6, with 117 members and guests present. The room and tables were beautifully decorated and the highlight of the setting was a tree with the usual Christmas ornaments.

Santa Claus was on hand to greet everyone and he had pictures taken with each family group.

Following the dinner, movies were shown of previous Christmas parties, after which Dr. Marcus Farrell led the singing of Christmas carols. He was accompanied at the piano by Mrs. John F. McCuskey.

Mrs. Marcus Farrell and members of the hospital aid committee displayed gifts prepared for distribution to the hospitals.

Arrangements for the meeting were made by Mesdames Bernard Wilkinson, D. H. Lough, A. J. Weaver, Darrell Wilkinson, Marcus Farrell, Francis Genin, and Jack T. Gocke.—Mrs. Paul R. Gordon, Correspondent.

* * * *

### MARION

Mrs. J. J. Jenkins, Sr. of Farmington, was the guest speaker at a meeting of the Woman's Auxiliary to the Marion County Medical Society which was held at the Fairmont Hotel in that city on November 24.

She presented an interesting talk on her recent trip abroad, and also showed color slides.

Mrs. O. M. Goodwin, the president, presided at the meeting and reports were presented on legislation, nurses scholarships, membership, and the American Medical Education Foundation.

Mrs. J. J. Jenkins, Jr., of Fairmont, was in charge of arrangements for the dinner meeting.—Mrs. William T. Lawson, Correspondent.

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### McDOWELL

Mrs. Pat A. Tuckwiller and Mrs. A. C. Chandler, both of Charleston, were the guest speakers at a meeting of the Woman's Auxiliary to the McDowell County Medical Society which was held at the home of Dr. and Mrs. Ray E. Burger in Welch on November 18.

Mrs. Tuckwiller is fourth vice president of the State Auxiliary and Mrs. Chandler is the program chairman for the annual meeting. Both women discussed auxiliary activities on the local, state and national levels.

Mrs. Charles B. Chapman presented an interesting report on the mental health program in McDowell county. She stated that "mental health is the nation's foremost medical problem today and that is why it is so important that every community have such a program to aid our aging population."

The Auxiliary voted unanimously to make contributions to the United Appeal and Salvation Army Cheer funds.

Mrs. Dante Castrodale, the president, presided at the meeting, and Mrs. Guy E. Irvin served as co-hostess with Mrs. Burger.—Mrs. J. H. Smith, Correspondent.

* * * *

### OHIO

Mrs. Spencer Glascock was the guest speaker at a luncheon meeting of the Woman's Auxiliary to the Ohio County Medical Society, which was held at the Wheeling Country Club on November 24.

Mrs. Glascock, who formerly served as an official hostess at Williamsburg, Virginia, presented an interesting talk on "The Williamsburg Story." She appeared in costume and used color slides to illustrate her talk.

Mrs. John G. Thoner, the president, presided at the meeting and hostesses for the luncheon were Mesdames Martin D. Reiter, Albert M. Valentine, John S. Meier, Charles D. Hershey, Harry S. Weeks, Jr., and Ross O. Bell, Jr.—Mrs. Robert S. Robbins, Publicity Chairman.

* * * *

### PARKERSBURG ACADEMY

Dr. Charles L. Goodhand and Dr. Jack J. Stark were the guest speakers at a recent luncheon meeting of the Woman's Auxiliary to the Parkersburg Academy of Medicine which was held at the Chancellor Hotel in Parkersburg.

Dr. Goodhand, who is chairman of the Advisory Board to the Auxiliary and also a member of the Legislative Committee of the State Medical Association, discussed legislation of interest to the medical profession, with emphasis on the Forand Bill which is now before the Ways and Means Committee of the House of Representatives.

Doctor Stark presented a tape recording on the prison war camps in Korea, which included a discussion of the techniques practiced by the Communists in their "brainwashing campaign."

Mrs. Edward Shupala, the president, presided at the meeting and the hostesses were Mesdames Jack J.

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Stark, Richard W. Corbitt, Robert K. Fankhauser, Faye Perry Greene, Jr., and Logan W. Hovis.—Mrs. George Gevas, Correspondent.

* * * *

### POTOMAC VALLEY

Mrs. R. R. Pittman of Marlinton, president of the Woman's Auxiliary to the West Virginia State Medical Association, was the guest speaker at a luncheon meeting of the Woman's Auxiliary to the Potomac Valley Medical Society which was held recently at the McNeill Hotel in Moorefield.

She outlined the work of the component auxiliaries throughout the state and stated that special emphasis is being placed upon the furtherance of better health in the community. She also reviewed the work that is being done in mental health, problems of the aging, safety at home, rural health and recruitment of young people for various medical careers.

Mrs. H. Luke Eye of Franklin, the president, presided at the meeting and the guest speaker was introduced by Mrs. V. L. Dyer of Petersburg, first vice president of the State Auxiliary. Mrs. M. H. Maxwell of Moorefield was in charge of arrangements for the luncheon meeting.—Mrs. Paul R. Wilson, Correspondent.

---

There are many arts among men, the knowledge of which is acquired bit by bit by experience, for it is experience that causeth our life to move forward by the skill we acquire, while want of experience subjects us to the effect of chance.—Plato.

# Book Reviews

**THE PHYSICIAN AND THE LAW—By Rowland H. Long, Member Massachusetts and New York Bars and Assistant Professor in Forensic Medicine, New York University Post-Graduate Medical School. Pp. 302. Appleton-Century-Crofts, Inc., 35 W. 32nd Street, New York 1, N. Y. 1959. Second Edition. Price $5.95.**

The perusual of this very interesting book has been a very informative and somewhat awesome experience. One would assume that after nearly forty years of practice there would be little in the field of forensic medicine which had not come into the knowledge or experience of a physician. The opportunity of reviewing the known and learning the many unconsidered facets of legal responsibility should be grasped by every medical man.

The author is an attorney with many years of experience in legal medicine. He is also a professor of forensic medicine at New York University. In this text he has had the very able collaboration of Dr. Milton Helpern, chief medical examiner in New York City.

Although the entire contents make interesting reading, your reviewer would call particular attention to the general discussion of malpractice with its many illustrative cases, the implied and actual forensic responsibilities of the physician, and his means of defense against alleged faults.


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The rather complete discussion on privileged communications as they affect the physician is of especial interest to West Virginia physicians because there is no such thing legally in our state, even though it is allowed in certain courts. This fact alone should stimulate activity in our medical organizations to strive for the enactment of such legislation.

The book should be available for reference to every physician in the State.—James S. Klumpp, M. D.

* * * *

**OBSERVATIONS ON "DIRECT ANALYSIS"—THE THERAPEUTIC TECHNIQUE OF JOHN N. ROSEN—By Morris W. Brody, M. D., member of the staff of Temple University's Department of Psychiatry, Philadelphia. Pp. 104. Vantage Press, Inc., 120 West 31 Street, New York 1, N. Y. 1959. Price $2.95.**

Morris W. Brody, M. D., initiates an anticipated series of studies from the Institute for Direct Analysis at Temple University. His sole purpose is to describe the technique utilized in "direct analysis" as devised and practiced by Dr. John N. Rosen.

Clearly and concisely the first impression that direct analysis is a type of therapy that offers healing love is corrected, as Doctor Rosen now claims "love without aggression is something other than love". Doctor Brody reports and documents the unique persuasions of Doctor Rosen that form the core of his technique: (1) to vigorously confront the patient with psychoanalytic interpretations, (2) to drum the interpretation into the patient's head, (3) the patient can then accept the interpretation and be appraised as intelligent or reject it and be considered stupid, and (4) to evoke guilt in the patient as opposed to insight. This may partially explain why Doctor Rosen insists that the best therapists are those who have been, possibly are, psychotic.

The book is replete with actual interviews in which the perennial preoccupations of psychoanalysts, sex and religion, are foisted upon the patient. Patient: "I want to live." Doctor: "You will live with my care. I am loving you. I will be your God. . . You are allowed to have my breasts." Patient: "To love—love everything." Doctor: "That is my command. I am God." (p. 59).

The author observes that while patients may resist the demands of Doctor Rosen, the group of training analysts never does because complete respect and obedience are required. The trainees are always compliantly present during Doctor Rosen's treatments. His attitude toward the patient, which he claims is essential to treatment, is never to let him forget that he is crazy and stupid. He assumes that the patient is completely without dignity and sensitivity, and he will discuss the patient before observers without regard for the feelings of the patient.

This apotheosis of the cult of the individual may achieve one purpose. For those practitioners of the healing arts who at times feel guilty over lapses in prudential judgment in their zeal to heal will find feelings of superiority replacing their guilt after reading this book.—J. T. Laird, Ph.D.

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## Books Received

**A DOCTOR ENJOYS SHERLOCK HOLMES**—By Edward J. Van Liere, M. D., Ph.D., Dean of the West Virginia University School of Medicine, Morgantown. Vantage Press, Inc., 120 West 31st Street, New York 1, New York. 1959. Price $3.00.

* * * *

**THE CHEMICAL PREVENTION OF CARDIAC NECROSES**—By Hans Selye, M. D., Ph.D., D.Sc., Professor and Director of the Institute of Experimental Medicine and Surgery, University of Montreal, Canada. Pp. 235, with illustrations and tables. The Ronald Press Company, 15 East 26th Street, New York City. 1958. Price $7.50.


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# Correspondence

**OFFICE FOR DEPENDENTS' MEDICAL CARE**
**OFFICE OF THE SURGEON GENERAL, U. S. ARMY**
**Washington 25, D. C.**

30 October 1959

Dependents' Medical Care Program
ODMC Letter No. 11-59

West Virginia State Medical Assn.,
Box 1031
Charleston 24, West Virginia

RETURN OF INFORMATION TO THE INTERNAL REVENUE SERVICE OF PAYMENTS OF $600 OR MORE MADE TO PHYSICIANS

1. The Treasury Department, Internal Revenue Service, has made the following Revenue Ruling 59-328:

Fiscal Administrators for Medical Societies or Societies acting as Fiscal Administrators must file a separate Form 1099, U.S. Information Return for Calendar Year with the District Director of Internal Revenue for each physician participating in the Program to whom it makes payments of $600 or more in a taxable year.

2. The following is quoted from the ruling:

"Section 6041 (a) of the Internal Revenue Code


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"Since under the terms of the contract, the Fiscal Administrator is charged with making the payments, such administrator is the one making payment for the purposes of Section 6041.

"Accordingly, based upon the above information, it is held that the fiscal administrator, or in this case, the Blue Cross-Blue Shield Medical Service, is required to file Forms 1099. A separate Form 1099 must be furnished by the Blue Cross-Blue Shield for each physician to whom it makes payments of $600 or more in any taxable year."

2. Fiscal Administrators should comply with the foregoing ruling.

(Signed) Floyd L. Wergeland
Brigadier General, MC
Executive Director

Official for Use of Contractors
Dependents' Medical Care Program:

(Signed) Walker W. Evans
Lt. Colonel, MSC
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Office for Dependents' Medical Care.

## Coffee Break Trends

Coffee break habits are changing as twice-a-day breaks spread, reports the Pan-American Coffee Bureau. In 1957, outside eating places were visited during coffee breaks by 14% of factory workers, 26% of office workers and 52% of store workers. Today, those leaving jobs at break time amount to only five per cent of factory workers, 20% of office workers and 23% of store workers.

Today, 10 million workers get two breaks daily, compared to six million in 1956. Of all coffee breaks, 60% are taken by workers at their work stations or desks.—Industrial Relations News.

## Space Medicine

Man has decided that the time is close at hand when he will be able to explore space on a personal basis. With man's great curiosity and propensity for breaching barriers into the unknown to gain new knowledge and demonstrate his courage and competence, it is highly doubtful that he will let the first reasonable opportunity pass unheeded. Space exploration will be of such magnitude that no man can foresee its consequences.

Space medicine, at first glance, undoubtedly appears to many people as a capricious or whimsical idea of its proponents. However, upon closer examination, space medicine, with its concomitant medical problems, is already here—an infant, but indubitably here!—Journal, Medical Assn., State of Alabama.

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**REFERENCES:** (1) Leming, B. H., Jr., & Flanigan, C., Jr., in Welch, H., & Marti-Ibânez, E.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 414. (2) Goslings, W. R. O., & Buchli, K.: *Arch. Int. Med.* **102**:691, 1958. (3) Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* **9**:38, 1959. (4) Metzger, W. I., in Welch, H., & Marti-Ibânez, E.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 966. (5) Fischer, H. G.: *Deutsche med. Wchnschr.* **84**:257, 1959. (6) Borchardt, K. A.: *Antibiotics & Chemother.* **8**:564, 1958. (7) Schneierson, S. S.: *J. Mt. Sinai Hosp. New York* **25**:52, 1958. (8) Waisbren, B. A.: *Wisconsin M. J.* **57**:89, 1958.

*Adapted from Leming & Flanigan.[1]

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FEBRUARY
1960

Vol. 56 No. 2

# The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.

Member 1960

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Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. *80*:481 (Oct.) 1958. 2. Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 3. Mathews, F. P.: Am. J. Psychiat. *114*:1034 (May) 1958.

SEARLE



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APR 3 1961

# WVU Medical Center
# —News—

A STUDENT loan fund has been created in honor of Dr. Edward J. Van Liere, who will retire as Dean of the West Virginia University School of Medicine at the end of the current school term. During the month of December, more than 2,100 letters were mailed to all the known alumni of the School of Medicine and all members of the West Virginia State Medical Association.

Response to the letter has been most gratifying. Eighty-six replies were received during the first two weeks and the average donation was $50. There were two donations of $250.

All who know Dean Van Liere are aware of his keen interest in students as individuals, so it seemed fitting to establish a substantial loan fund in his name. At the present time, approximately $20,000 is available for this purpose.

Loans from this fund are restricted to a maximum of $500 per student per year. This maximum loan will cover less than half of the minimum cost of one year of education and loans are currently totaling approximately $5,000 each year. With larger classes and with expansion of the School of Medicine to four years, it is estimated that at least $150,000 will be needed to aid in the support of needy students.

Those wishing to contribute to the loan fund should make checks payable to the Edward J. Van Liere Loan Fund, and mail same to Clark K. Sleeth, M. D., Room 1144, WVU Medical Center, Morgantown, W. Va.

### Director of Nursing Service Appointed

Miss Audrey Edith Windemuth of Minneapolis, Minnesota, has been appointed director of Nursing Service of the Teaching Hospital at the WVU Medical Center. The appointment which is effective February 1, 1960, was announced by President Elvis J. Stahr, Jr.

Miss Windemuth attended the University of North Dakota and received a B. S. degree from the University of Minnesota in 1939. She also received a Master's Degree in Nursing Service Administration from that school in 1959.

She has been serving as Nursing Supervisor and Instructor at the University of Minnesota Hospitals since 1957, and prior to that served 12 years as Outpatient Department Senior Clinic Nurse.

Miss Windemuth is the author of a book, "The Nurse and the Outpatient Department," which was published by the Macmillan Company in 1957.

• Compiled from material furnished by John B. Horley, M. D., Assistant Professor of Pathology and Public Information Officer at the WVU Medical Center in Morgantown, W. Va.

### Benedum Medical Scholarships

Three students in the School of Medicine have been awarded Claude Worthington Benedum medical scholarships for the current school year, according to Joseph C. Gluck, chairman of the University Committee on Prizes, Scholarships and Loan Funds.

Recipients of the awards, valued at $400 each, are Stanley B. Gross of Morgantown, Thomas J. Nassif of Rowlesburg, and Edward A. Zakaib of Charleston. All are second-year students in the School of Medicine.

These scholarships were established in honor of the late Claude Worthington Benedum, son of M. L. Benedum, Pittsburgh oil pioneer and a native of Bridgeport. The awards to medical students comprise one of several forms of financial assistance to University students maintained by the Benedum family.

### News of Faculty Members

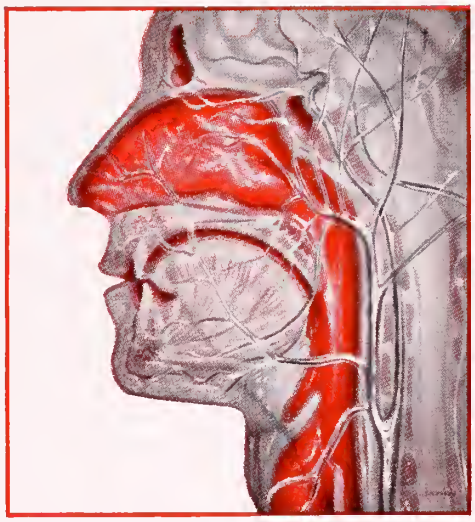
Dean Van Liere participated in a discussion of "Federal Health Programs" during a meeting of the American Association of Medical Colleges in Chicago, January 9-10. The program was devoted primarily to the general question of the Federal Government and its relationship to medical education and medical schools.

Dean Van Liere also visited the School of Aviation Medicine at Randolph Field, Texas, December 16-20, where he consulted with various Air Force officials on "Climatization to Altitude."

A $10,000 research grant has been received from the National Institutes of Health of the USPHS to support a continuing study of the action of parathyroid hormone on bone which is being conducted by Dr. Alexander D. Kenny, associate professor of pharmacology.

The University has also received a $5,175 grant from the same source to support investigations of capillary beds by Dr. Charles C. Boyer, associate professor of gross and neurological anatomy. He is using the grant, now in its third year, to continue his study of pathological renal glomeruli, diseased capillary beds in the part of the kidney which is principally responsible for filtration.

# reaches all nasal and paranasal membranes *systemically*[1]



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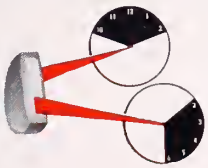

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1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

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# The Month in Washington

• From the Washington Office of the American Medical Association

OVERSHADOWING all other developments from the standpoint of the medical profession was the flat prediction made recently by a high Administration official and key lawmakers that Congress this year would vote some sort of liberalization of the Social Security program.

There was general agreement that Congress would broaden the Social Security plan for permanently and totally disabled persons by removing the requirement that a person has to be at least 50 years of age before receiving such benefits; however, there were forecasts of even further liberalization.

House Speaker Sam Rayburn (D., Texas.) said monthly cash benefits also may be boosted. On the other hand, the House leader said he believed a majority of the House Ways and Means Committee were opposed to the disputed Forand Bill that would finance partial health care for the elderly through higher Social Security taxes at an estimated extra cost of $2 billion annually. As a result, he said he did not think "there was a great deal of chance for it." But the AFL-CIO and some Congressional backers of the highly controversial bill were urging Congress to approve it this year.

### Administration To Offer Program

Arthur S. Flemming, Secretary of Health, Education and Welfare, asserted that the Administration is planning to offer a program aimed at assisting needy aged to meet health bills, but gave no details. The official noted that the Administration has firmly opposed the Forand-type approach on grounds it would destroy the rapid progress in meeting the problem through private means. But Flemming, in a speech before the American Association of University Teachers of Insurance, said the Administration has an obligation "to stay with it" until it arrives at a plan.

Congress has extended the Social Security program every presidential election year since 1948, and 1960 appeared to be no exception. Whether or not the issue of medical care for the aged will be included was one of the big question marks early in the session.

Shortly before Congress convened, the Boards of Trustees of the AMA and the American Hospital Association, in a joint resolution, pledged to "mobilize their full resources to accelerate the development of adequately financed health care programs for needy persons—especially the aged needy—" at state and local levels.

### 'Not Designed To Assist the Needy'

The Boards said Forand-type legislation is "not designed to assist the needy, since it applies to all Social Security beneficiaries and excludes the majority of needy persons, who are not eligible for Social Security benefits."

Following the action, Dr. Louis M. Orr, AMA President, and three other AMA officials, Dr. E. Vincent Askey, President-Elect, Dr. F. J. L. Blasingame, Executive Vice President, and Dr. Ernest B. Howard, Assistant Executive Vice President, visited Vice President Richard M. Nixon at his Washington Office. They told the Vice President that by the end of this year an estimated 60 per cent of the nation's aged persons who want and need voluntary health insurance will have it.

Mr. Nixon, according to the officials, was delighted to receive the information and "very much interested" in the program of voluntary health insurance for the aged.

### Miscellaneous

Physicians who are officers of qualified clinics would be entitled to deduct as business expenses money set aside for their retirement under a proposed regulation of the Internal Revenue Service. The decision climaxed a five-year effort of a group of Montana physicians to secure such tax treatment, and marked an important tax development for physicians who operate clinics. Self-employed physicians continue to be barred from similar tax treatment, though there is legislation before the Senate Finance Committee that would afford them tax deferrals on funds set aside for retirement.

## Maintaining a Wholesome Relationship

At no time in our history has our profession been under as close scrutiny as it is today. Too often we are being taken to task. We can overcome much of this criticism by furnishing competent and satisfactory service whenever needed and by submitting fair and reasonable bills for this service.

As we have said so often before, there must be dedication on the part of the doctor of medicine so that the time-honored, wholesome, doctor-patient relationship—so necessary to the practice of good medicine—will be maintained always.—Henry I. Fineberg, M. D., in New York State Journal of Medicine.

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# Obituaries

### DORSEY C. BEALL, M. D.

Dr. Dorsey C. Beall, 42, of Morgantown, died at his home in that city on January 11, 1960. He had been in ill health for the past year.

Doctor Beall was born near Grafton on April 18, 1917. He was a graduate of Grafton High School and received his B.S. degree from West Virginia University in 1948. He graduated from the Medical College of Virginia in 1950 and served his internship at Charleston General Hospital. Following his internship at Charleston, he was awarded a special three-year residency in dermatology at Bellevue Hospital, New York City. He was chief resident in dermatology there, 1954-1955.

He was a member of the Monongalia County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

In addition to his parents, he is survived by a brother, Joseph V. Gamsjager, a half sister, Mrs. Ruth Daff, and a half brother, John Junior Gordon, all of Grafton.

* * * *

### PAUL R. COPELAND, M. D.

Dr. Paul R. Copeland, 65, of Beckley, died at a hospital in that city on December 12, 1959, following a short illness.

Doctor Copeland retired as manager of the VA Hospital in Beckley in August, 1959. He had served in that capacity since 1954. Previously he had been manager of the VA Hospital in Huntington.

He spent practically his entire professional life in government service. He had been in private practice but six months when he enlisted for military service in World War I. After being released from the Army Medical Corps in 1919, he engaged in private practice for a few months at Clifton Hill, Missouri. He entered the United States Public Health Service in 1920 and remained in government employment until his retirement.

Besides his widow, he is survived by two sons, John B. of Kalamazoo, Michigan, and Paul, Jr., of Greens Farms, Connecticut; his mother, Mrs. Della Copeland of Carbondale, Illinois; and two sisters, Mrs. Ruth Peterson of Carbondale and Mrs. Carl Cundiff of Springfield, Illinois.

* * * *

### CARL EDGAR MOREHEAD, M. D.

Dr. Carl Edgar Morehead, 51, of Parkersburg, died at his home in that city, January 6, 1960, following a heart attack.

Doctor Morehead was born on January 22, 1908, in Evansville, Indiana, son of Maurice F. Morehead and the late Mrs. Bertha (McCune) Morehead.

He attended the University of Louisville for six years, two of which were spent in the study of pharmacy, and the remainder in general medicine. He received

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J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

**Pediatrics:**
CORA C. LENOX, M. D.

**Anatomical Pathology:**
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his M. D. degree from the University of Louisville School of Medicine in 1934 and served his internship at Louisville City Hospital. After practicing for a few months in Louisville, he located in Wirt County, where he was connected with a CCC Camp.

He had been engaged in practice at Parkersburg since 1940 and had served as county health officer of Wood County.

He was a member of the Academy of Medicine of Parkersburg, the West Virginia State Medical Association and the American Medical Association.

Besides his widow, the former Gladys Rice, he is survived by his father and his stepmother, Mrs. Pearl Morehead, both of Evansville, Indiana; two daughters, Mary Cameron Morehead, a senior at Ohio University in Athens, and Sandra Kathleen, a freshman at Greenbrier College in Lewisburg; a son, Michael Augustus at home; and a sister, Mrs. Ethel Mae McCullough of Birmingham, Michigan.

## 'Loving Care' Needed

Not all crying is hunger, gas, or gastrointestinal dysfunction. Many infants cry seeking only human contacts, pleasant and harmonious sounds, and the warmth and security of being held in arms. Surely there is no sin to taking an infant in the arms, rocking in a rocking chair and softly singing a lullaby. This has cured more colic than all the tidal waves of "green drops" that have been squirted down throats of struggling infants.—F. Michael Smith, Jr., M. D., in Journal, La. State Medical Society.

## PG Course in Urology

A postgraduate course on the subject of "advances in Urology," will be presented by the Frank E. Bunts Educational Institute in the North Clinic Building of the Cleveland Clinic Foundation, in Cleveland, March 16-17, 1960.

The registration fee is $30.00, but there will be no fee for interns and residents. Applications for registration should be mailed just as soon as possible to the Education Secretary, The Frank E. Bunts Educational Institute, 2020 E. 93rd Street, Cleveland 6, Ohio. Check for $5.00, payable to the Institute, should accompany each application for registration.

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# County Societies

### EASTERN PANHANDLE

Dr. George F. Pugh, Jr., was elected president of the Eastern Panhandle Medical Society at the regular monthly dinner meeting held at the Shenandoah Hotel in Martinsburg on December 9. He succeeds Dr. W. R. McCune.

Other officers were elected as follows: first vice president, Dr. Jules F. Langlet; second vice president, Dr. N. B. Groves; and secretary-treasurer, Dr. F. A. Hamilton, Jr.

The Society went on record as endorsing the joint Resolution of the American Medical Association and the American Hospital Association concerning medical care for the needy.

Plans to incorporate the Annual Postgraduate Institute at Martinsburg were considered and approved and referred to committee for study.—F. A. Hamilton, Jr., M. D., Secretary.

* * * *

### HARRISON

Dr. L. D. Zinn was the guest speaker before the regular monthly meeting of the Harrison County Medical Society at the Stonewall Jackson Hotel in Clarksburg on January 7, 1960. He discussed "The Differential Diagnosis Between Neuralgia and Angina Pain as a Cause of Chest Pain."

At the business meeting following the scientific session, Dr. E. B. Wright was elected to honorary membership in the Society.—Andrew J. Weaver, M. D., Secretary.

* * * *

### MERCER

The annual Christmas banquet of the Mercer County Medical Society was held at the Bluefield Country Club on December 14. Wives of the members and other honored guests were welcomed by the president, Dr. Gordon L. Todd, Jr., who also expressed sincere thanks to the Woman's Auxiliary for arranging tasteful decorations. During the evening, Mrs. Ella Nash Jarrell and Mr. Garland Bruce presented an interesting and enjoyable program of musical entertainment.

At the business meeting, following the entertainment program, the following officers were elected to serve during 1960: President, Dr. W. E. Copenhaver; vice president, Dr. Henry F. Warden, Jr.; secretary-treasurer, Dr. John J. Mahood; delegate, Dr. Wade H. St. Clair, Jr.; alternates, Drs. John I. Markell and Richard O. Rogers, Jr.; board of censors, Dr. E. Lyle Gage; and advice and deportment, Dr. Robert S. Gatherum, Jr.—John J. Mahood, M. D., Secretary.

### Take Time to Read

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# Woman's Auxiliary

to the

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*First Vice President:* Mrs. V. L. Dyer, Petersburg
*Second Vice President:* Mrs. Myer Bogarad, Weirton
*Third Vice President:* Mrs. John F. Morris, Huntington
*Fourth Vice President:* Mrs. P. A. Tuckwiller, Charleston
*Treasurer:* Mrs. George A. Curry, Morgantown
*Recording Secretary:* Mrs. Rupert W. Powell, Fairmont
*Corresponding Secretary:* Mrs. James W. Hamilton, Marlinton
*Parliamentarian:* Mrs. J. Preston Lilly, Charleston

### HARRISON

Mrs. Roger Morgan of Clarksburg was the guest speaker before the regular monthly dinner meeting of the Woman's Auxiliary to the Harrison County Medical Society held at the Stonewall Jackson Hotel in Clarksburg on January 7.

The speaker discussed the nursing profession, its aims and objectives, its history, and progress from the era of Florence Nightingale to the present time. She also stressed the great need for more nurses in this state and throughout the country.

Dr. George F. Evans discussed every phase of the Forand Bill now pending in Congress and solicited the aid of the Auxiliary in the defeat of this type of legislation.

Guests of honor were faculty sponsors and officers of the medical careers clubs in the local high schools and at Lumberport and Shinnston.

Mrs. Robert S. Wilson, health careers chairman, and Mrs. Richard V. Lynch, Jr., community service chairman, arranged the program for the meeting.

Hostesses for the social hour preceding the dinner were Mesdames H. V. Thomas, James R. McClung, Marcus E. Farrell and James E. Wilson, Jr.

The president, Mrs. James A. Thompson, welcomed the members and presided at the business meeting following the formal program.—Mrs. Paul E. Gordon, Correspondent.

* * * *

### KANAWHA

The regular monthly luncheon meeting of the Woman's Auxiliary to the Kanawha Medical Society was held January 12 at Winn's Restaurant in Charleston, with Mrs. George Miyakawa presiding, and with Mrs. Joel Allen serving as chairman of the hostesses.

Dr. Margaret T. Ross, Director of Hillcrest and executive secretary of the West Virginia Association for Mental Health, was the guest speaker. She told the members of the Auxiliary and guests that we should all be proud to have Hillcrest in the Charleston area, where emotionally disturbed children may be treated. She said that this institution is one of 43 such centers in the United States.

## OFFICERS OF COUNTY AUXILIARIES

| Society | President | | Correspondent | |
|---|---|---|---|---|
| Boone | Mrs. O. D. MacCallum | Madison | Mrs. Wyson Curry | Madison |
| Cabell | Mrs. Lee F. Dabbs | Huntington | Mrs. Jack Leckie | Huntington |
| Central West Virginia | Mrs. Elden H. Pertz | Weston | Mrs. George E. Farrell | Webster Springs |
| Eastern Panhandle | Mrs. Curtis G. Power | Martinsburg | Mrs. Curtis G. Pawer | Martinsburg |
| Fayette | Mrs. R. S. Birckhead | Charlton Heights | Mrs. J. N. Jarrett | Oak Hill |
| Greenbrier Valley | Mrs. Lee B. Todd | Quinwood | Mrs. James W. Hamilton | Marlinton |
| Hancock | Mrs. George Rigas | Weirton | Mrs. Roy Conrad | Weirton |
| Harrison | Mrs. James A. Thompson | Clarksburg | Mrs. Paul E. Gordon | Clarksburg |
| Kanawha | Mrs. George Miyakawa | Charleston | Mrs. W. W. Currence | South Charleston |
| Logan | Mrs. Ray M. Kessel | Logan | Mrs. Henry Bobroff | Man |
| Marion | Mrs. O. M. Goodwin | Fairmont | Mrs. William T. Lawson | Fairmont |
| McDowell | Mrs. Dante Castrodale | Welch | Mrs. J. H. Smith | Welch |
| Mercer | Mrs. Gordon L. Tadd, Jr. | Princeton | Mrs. Robert S. Gatherum | Bluefield |
| Mingo | Mrs. W. W. Scott | Williamson | Mrs. Robert Tchou | Williamson |
| Monongolia | Mrs. Hubert A. Shaffer | Morgantown | Mrs. Hubert Marshall | Morgantown |
| Ohio | Mrs. John G. Thoner | Wheeling | Mrs. Rabert S. Robbins | Wheeling |
| Potomac Valley | Mrs. Luke Eye | Franklin | Mrs. Paul R. Wilsan | Piedmont |
| Preston | Mrs. Donald P. Brown | Kingwood | Mrs. Donald P. Brawn | Kingwood |
| Raleigh | Mrs. F. Vivan Lilly | Beckley | Mrs. Charles I. Allen | Beckley |
| Taylor | Mrs. Paul P. Warden | Graftan | Mrs. H. N. Shanes | Grafton |
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| Wyoming | Mrs. Mario Cardenas | Mullens | Mrs. C. T. Upchurch | Oceana |

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The speaker expressed the opinion that mental health needs three things, (a) more research, (b) better clinical facilities, and (3) better education of the public.—Mrs. William W. Currence, Correspondent.

* * * *

### MINGO

A breakfast meeting of the Woman's Auxiliary to the Mingo County Medical Society was held December 5 at the home of Dr. and Mrs. A. H. Henderson in South Williamson. Mrs. Fred Wyttenbach served as co-hostess, and guests were presented with Christmas corsages.

At the conclusion of the meal, a short business session was conducted by the president, Mrs. W. W. Scott, and reports were received and plans formulated for future activities.

Donations were ordered made to two worthy projects, Hillcrest, Inc., Charleston, and the "Clothes Closet," a local organization dedicated to helping needy school children.

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Members of the Woman's Auxiliary to the Mingo County Medical Society were guests at the annual dinner meeting of the Society held on December 18 in the Venetian Room of the Mountaineer Hotel in Williamson.

Corsages of red carnations were presented to each member of the Auxiliary upon her arrival at the hotel. Tables were beautifully decorated in the holiday motif.

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Dr. Jacob C. Huffman of Buckhannon, President of the West Virginia State Medical Association, and his wife, a past president of the State Auxiliary, were honor guests at the meeting.—Mrs. Robert Tchou, Correspondent.

* * * *

### MONONGALIA

Mrs. Hubert A. Shaffer presided at the December meeting of the Woman's Auxiliary to the Monongalia County Medical Society which was held at the home of Dr. and Mrs. H. A. Rich in Morgantown.

Mrs. M. L. Hobbs presented an interesting and informative talk on "Legislation," and Mrs. Clark K. Sleeth and Mrs. Robert J. Fleming presented two skits entitled "The Ladies Louse It Up" and "Ladies Work Wonders," illustrating the improper and proper way to visit a congressman.

Reports on pending medical legislation and civil defense were also presented by Mrs. Robert J. Nottingham and Mrs. Sleeth, and Mrs. Clement A. Smith reported on the AMEF campaign.

Mrs. Lucien M. Strawn was in charge of arrangements for the meeting and she was assisted by Mesdames C. Truman Thompson, Enrico Paparozzi, Arthur W. Kelley, Glenn Ashworth and Maynard P. Pride.—Mrs. Hubert T. Marshall, Publicity Chairman.

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It is easier swallowing words than it is having to eat them.—Anon.

# Book Reviews

**SYNOPSIS OF GYNECOLOGY—By Robert James Crossen, M. D., Associate Professor of Clinical Ob. & Gyn., Washington University School of Medicine, St. Louis; Daniel Winston Beacham, M. D., Assistant Professor of Clinical Ob. & Gyn., Tulane University School of Medicine, New Orleans; and Woodward Davis Beacham, M. D., Professor of Clinical Ob. & Gyn., Tulane University School of Medicine. Pp. 340, with illustrations. Fifth edition. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri. 1959. Price, $6.50.**

The fifth edition of the Synopsis of Gynecology is a complete revision under the coauthorship of Drs. Daniel W. Beacham and Woodward D. Beacham, resulting in a concise but complete outline of the specialty, and fulfilling the intent of Dr. Crossen to publish a short, usable and inexpensive work on gynecology which would give the student and the general practitioner a rounded background of gynecologic information as well as recent advances in this field.

Several chapters are devoted to detailed discussions which would merit a place in any standard textbook and reward the student who would memorize the leading points in these chapters.

The chapter on anatomy and physiology includes streamlined coverage of anatomy, the endocrine functions of the ovaries and the endometrium, with excel-

lent descriptions of menstruation and ovluation. The technique of the gynecologic examination is described in such thorough detail that the student will be rewarded by his accomplishments in the evaluation of the female pelvis both vaginally and abdominally.

The portion on diagnosis describes all instruments used in gynecologic diagnosis, with discussion of the techniques of vaginal smears, cervical biopsy, culdoscopy, the fern test, culdocentesis, pregnancy tests and endocrine investigations. The authors correlate the pitfalls in diagnosis under errors in history, errors about a pelvic mass, false assumptions and errors about tests in such an inclusive descriptive manner, which will undoubtedly result in some reflection by the examiner before he makes a diagnosis.

At the end of each chapter selected references cover the salient points for the student seeking detailed information on these subjects. The new chapter on endometriosis is modern in etiology, pathology, diagnosis and treatment, and the chapter on pregnancy complications covers abortion, ectopic pregnancy, hydatidiform mole, and choriocarcinoma. Diseases of the vagina includes cystocele, urethrocele, rectocele and enterocele.

Malpositions and lesions of the cervix with benign lesions of the uterus are thoroughly and excellently discussed. Malignant disease of the uterus includes carcinoma of the cervix, carcinoma of the endometrium and sarcoma. The chapter on ovarian tumors includes short capsule descriptions of all ovarian tumors both benign and malignant. Disturbances of function details discussions on amenorrhea, giving endocrine and ovarian causes; abnormal uterine bleeding; dysfunctional uterine bleeding; dysmenorrhea; premenstrual tension; dyspareunia; and sexual frigidity.

Infertility, diseases of the menopause and medicolegal points in gynecology complete this pocket outline of gynecology.

Much new information, including data on chromasomal and hormonal factors in intersexuality, the use of adrenal corticoids in the treatment of pelvic infections, and current opinion on the management of uterine displacement and prolapse, has been incorporated in the appropriate chapters.—Frederick H. Dobbs, M. D.

* * * *

**METABOLIC CARE OF THE SURGICAL PATIENT—By Francis D. Moore, M. D., Moseley Professor of Surgery, Harvard Medical School and Surgeon-in-Chief, Peter Bent Brigham Hospital. Illustrated by Mildred Codding, A. B., M. A., Surgical Artist, Department of Surgery, Harvard Medical School, Peter Bent Brigham Hospital. Pp. 1011, with 143 illustrations. Philadelphia and London: W. B. Saunders Company. 1959. Price $20.00.**

This book review was approached with all the anxieties naturally engendered by a treatise on electrolye and acid-base problems. Further dismaying was the size of the volume—over 900 pages. After laboriously reading this work, I firmly believe that the book belongs in the library of all surgeons; indeed many internists and general practitioners would be enlightened by its fundamental approach to clinical problems.


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I doubt that it is widely appreciated that the turning point in a patient with delirium tremens might be the administration of magnesium ion, or that in certain elderly patients their down-hill course might be reversed by hypertonic salt solution. The approach to these common problems is always clinical. I believe it is possible for the busy practitioner to get help by case-matching his problem with those in the book, skipping over much of the detail as long as the fundamental principles are understood.

Part One concerns the detailed physiology and metabolic features of convalescence and variations thereof. An extremely detailed review of the literature in this rapidly expanding field is difficult to read because of lack of continuity but serves well as an excellent bibliography. Of interest to clinicians is an excellent discussion of wound healing, emphasizing the primacy of wound metabolism at the expense of total body nutrition, and further elucidation of the phase of post-traumatic catabolism and the futility of attempts to effect positive nitrogen balance.

Part Two discusses alterations in blood volume with detailed physiologic explanations of the common, as well as uncommon, clinical problems encountered by all practitioners.

Part Three laboriously details fundamentals of the electrolyte and acid-base disturbances. A redeeming feature of this section is a very practical presentation of 19 of the commonest clinical patterns of derangement. This is an excellent section.

Part Four discusses the metabolic problems of starvation in surgical patients.

Part Five discusses visceral diseases in surgical patients. This is a most erudite dissection of the various metabolic and chemical compartments of specific diseases. Although the emphasis is on the etiology and treatment of chemical imbalances, this section would not be considered an academic exercise. In fact, many sound and practical non-chemical surgical and medical tips are offered to make this section of extreme value for any doctor who has a puzzling sick patient.

Part Six discusses care of wounds, fractures, and burns with very helpful explanations of the mechanism of all the common complications and many uncommon complications with clear-cut advice as to their correction.—Edgar F. Heiskell, Jr., M. D.

* * * *

**SCHIFFERES' FAMILY MEDICAL ENCYCLOPEDIA.—By Justus J. Schifferes, Ph. D., Livingston, New Jersey. Pp. 619. Pocket Books, Inc., 630 Fifth Avenue, New York 20, New York, 1959. Price (paper) $.50.**

The title of this volume fits its contents. It is a concise, yet comprehensive compendium of the many physical, mutual and emotional conditions occurring in the human being. Even though it is written in a style and choice of words required for lay comprehension, the descriptions and definitions can very well serve as a mental brush-up for the man of medicine. It might be surprising to many physicians to know the many forgotten interesting items which will be recalled by frequent casual reading of this book.

There is one possibility which might be considered harmful. I refer to the many hypochondriac patients who might be given additional emotional fuel in evaluating their complaints by having access to such a source of diagnostic and therapeutic information. On the whole, I believe the benefits gained by sensible use of the information and advice far outweigh any possible disadvantage.—J. S. Klumpp, M. D.

## Books Received

**MEDIEVAL AND RENAISSANCE MEDICINE.**—Benjamin L. Gordon, M. D., F.I.C.S. Pp. 843. Philosophical Library, Inc., 15 E. 40th Street, New York 16, New York. 1959. Price $10.00.

* * * *

**DOCTOR STRAND**—By Boris Sokoloff, M. D., Director of the Southern Bio-research Institute, Florida Southern College, Lakeland, Florida. Pp. 205. Vantage Press, Inc., 120 W. 31st St., New York 1, New York. 1960. Price $3.50.

* * * *

**THE STORY OF DISSECTION.**—By Jack Kevorkian, M. D. Pp. 80. Philosophical Library, Inc., 15 E. 40th Street, New York City. 1959. Price $3.75.

* * * *

**A PRACTICAL GUIDE FOR GENERAL SURGICAL MANAGEMENT.**—By Julian A. Sterling, M. D., Senior Attending in Surgery at the Albert Einstein Medical Center, Philadelphia. Pp. 67. Vantage Press, Inc. 1959. Price $3.00.

High heels were invented by a woman who had been kissed on the forehead.—Christopher Morley.


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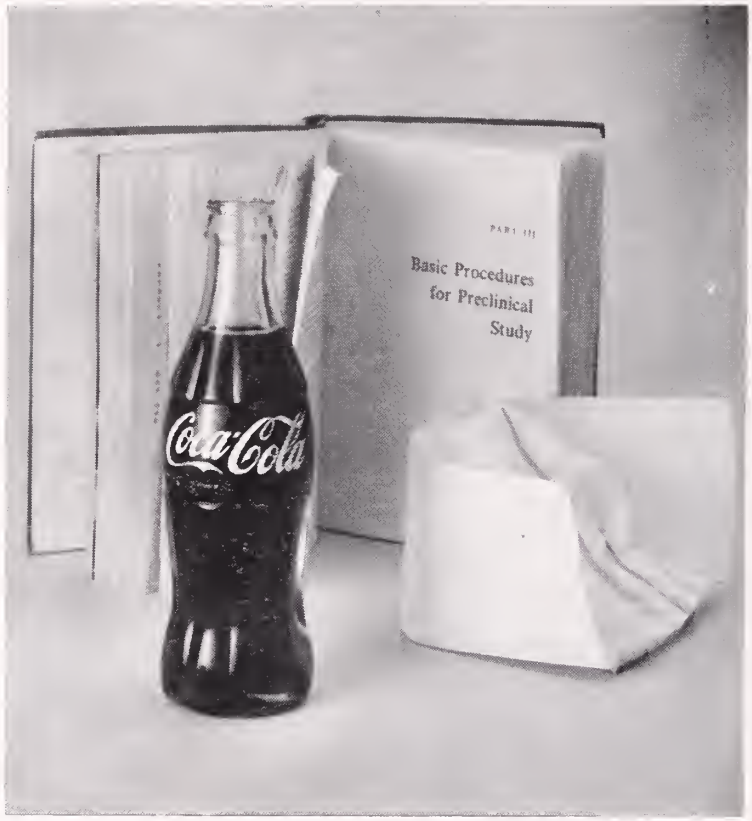


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The Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland will be held at the Alcazar, in Baltimore, April 20-22, 1960.

The first scientific session is scheduled for Wednesday afternoon and the second on Wednesday evening. Other sessions will be held morning and afternoon on April 21 and April 22.

The Presidential Dinner is scheduled for Thursday evening, April 21, at the Sheraton Belvedere Hotel. The principal speaker will be Dr. Virgil T. DeVault, Medical Director of Foreign Service and Department of State, Washington, D. C. His subject will be "Medicine Behind the Iron Curtain and Other Foreign Countries."

## Pan-Pacific Surgical Cong. To Meet In Honolulu, Sept. 27-Oct. 5.

The Eighth Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii, September 27 through October 5, 1960. All members of the medical profession are cordially invited to attend the meeting. An outstanding scientific program has been arranged, and ten surgical specialty sections will function simultaneously.

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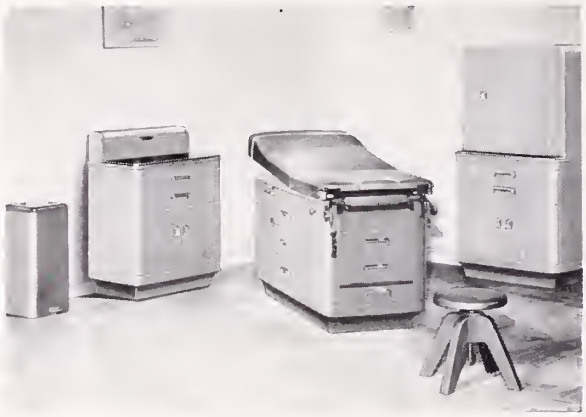

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## Pills With Sympathy

Illness is always a terrifying experience. There are always unknowns. The individual's routine is upset. Finances are disrupted. In many instances budgets are knocked out for years. Permanent changes in life may have to be made. Modern hospitals and doctors, with all of their complicated gear and procedure, can compound the fright the sick person is going through. Lack of understanding of what is being done and what is to be expected adds to the confusion. This is the time when a "feller needs a friend" and the doctor should be that friend. Doctors should take time to know their patients, to establish themselves as trusted advisors and guides through all of the complicated business of being ill.

Medicine is under criticism today. We hear on all sides that as doctors we are cold, indifferent, and interested only in the individual as a number and as a disease. The older practitioner had very little to work with and the basic knowledge of disease was meager, yet today he is enshrined and glorified. Why? Because his administrations were kindly with sympathy.

In our modern setting our opportunities to serve mankind are not decreased but multiplied a hundred fold. Human nature has not changed, but the practice of medicine has changed. People in their hours of need still want friends, comfort, and understanding. Let us all revaluate our personal relationship with patients and give our pills with sympathy—though they be of the miracle variety.—Westchester Medical Bulletin.

## Sabbatical for the Doctor

One of the aspects of the modern profession of medicine that has seemed incongruous and disturbing is the average doctor's lack of leisure. I do not mean, necessarily, leisure to go fishing or to play golf—though that, too, may be important. I mean leisure as it has been conceived in the best epochs and in the richest lives: the opportunity to think, to reflect imaginatively and to restore the batteries of creativity that constant toil drains low.

Sometimes, I have thought that licensing bodies should exact from the doctor the requirement that he take a regular sabbatical. But the pressures that make the doctor's day a harried round work against any prolonged time off. Nothing could be more sane than the tendency of group practice to introduce limits upon the demands made upon a doctor's time. Nothing could be more hopeful than the kind of provisions being made under some of the group health plans for regular periods of renewed study and research.

The medical groups are restoring in these ways something of the quality of a liberal profession that had been supposed to exist—but for a long time has not existed—in the career of the good doctor.—August Heckscher in New England Journal of Medicine.

Money and time are the heaviest burdens of life, and the unhappiest of all mortals are those who have more of either than they know how to use.—Samuel Johnson.


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## Crisis in Washington

The Forand crisis has compelled us to assume new roles of leadership. Our positive programs and studies have been vastly accelerated. Medical socioeconomics is catching up with medical science.

We make no bones about it: There are problems demanding solution. Without doubt, the most urgent problem facing physician and patient is that of preventing enactment of a faithless expedient in the name of health care. For the aging, the true nature of these problems is simply stated as adjustment to new opportunity, longer life, application of scientific advancement, and continued development of health care facilities and financing mechanisms.

In all areas, American medicine, our insurance industry, the prepayment plans, private organizations, and non-federal government agencies are meeting the challenge. Left alone, the job will be done effectively and efficiently by private, non-federal means.

For the physician, chronic illness is the major care difficulty with respect to the aged. In younger individuals, a crippling condition may be found in an otherwise healthy body, but in an older person it is often superimposed on the pathology of the aging process. Thus, in older patients, chronic and restorative care rarely can be separated from definitive treatment.

Where there is no pronounced chronic disease, the elderly patient who is acutely ill presents much less of a problem to the physician. We have both the scientific means and care facilities to meet this need effectively and economically.—M. Q. Ewing, M. D., in Journal, Mississippi State Medical Association.

## The Dynamics of Geriatrics

These remarks have to do with the "powers residual," that may be in evidence, or may be resurrected within the elderly personality. I am aiming my darts of inquiry towards those of advanced years, who are still actively employed; also I am making room for the semi-retired, the rehabilitants and even the timid invalids.

It is my urgent intention to promote certain old folks from the hex of "sittin' an' a-starin' an' a-rockin'."

As we grow older, there must develop within us a habit of healthful employment of leisure time, with creative interests hovering in the intimate neighborhood. Those of us in geriatric practice certainly could look sharply about us when observing the living conditions and activity propensities of our older population. A mere fusty room, a chair, a dresser, four walls and a stuffy atmosphere, plus a listless approach to the shards of life—all deserve a gerontological kick in the pants from the attending medico.

In addition to writing a prescription for health, we can also turn the knob of existence ever so slightly in the direction of activity—just enough to make the tumblers of the combination open the safe that reveals the freshness of existence.—C. Howard Ross, M. D., in Journal, Michigan State Medical Society.

## Chronologic Versus Biologic Time

Youth has been served during the first half of the twentieth century. It begins to appear that this emphasis has not infrequently been a detriment rather than a help where discipline and lack of guidance have rested while the youth was allowed "the freedom of expression."

Experience suggests in the study of family life and development, and in education, that no one particular age group should be favored over any other. The youth learns from the elderly, the elderly in turn can learn and grow through youth and its experience. Together they weave the social fabric. The time, then, has arrived when a clearer appreciation of maturity in terms of human experience is advisable.

Students of man, scientists, physicians, anthropologists sociologists and those engaged in the medical and the paramedical professions have abundant evidence that the measure of aging according to chronologic time is but an illusion. There are useful individuals in the eighties and elderly ones in the thirties and forties The stamina of tissues, biologic resiliency, responsiveness and ability to adjust to changing conditions represents a more accurate measure of an individual's life expectancy. Biologic time is a more accurate index of individual potential.—Edward L. Bortz, M. D., in Southern Medical Journal.

When it is dark enough you can see the stars.—Charles A. Beard.

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Vol. 56 No. 3

# The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Huntingtan

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone Dickens 4-4625.

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# WVU Medical Center
# —News—

• **Compiled from material furnished by John B. Harley, M. D., Assistant Professor of Pathology and Public Information Officer at the WVU Medical Center in Morgantown, W. Va.**

CONSTRUCTION work on the new WVU Teaching Hospital is substantially completed and University officials have approved acceptance of the 14-story, 2,156-room structure from the contractor, John McShain, Inc., of Baltimore, Maryland.

Plans are now under way for equipping and staffing 220 beds. Bids for patient room furniture were to have been opened on February 23 and bids for the purchase of other capital equipment needed to commission 220 beds wil go out in the next few weeks.

A 522-bed facility, the hospital will operate at approximately half of its potential during its early months. The space will be extended as its program builds and public need develops. Plans at present are to open the hospital for patient care on or about August 1. The Teaching Hospital must be open and operating by September 15 in order to provide clinical teaching facilities for students enrolled in the third-year class.

### Fayette County Loan Fund

The Fayette County Medical Society has established a loan fund to aid students in the second, third and fourth year classes in the School of Medicine. The Society's initial contribution to the fund was $2,390.86.

The fund is intended primarily for the use of upperclassmen, and residents of Fayette County will be given preferential consideration. All recipients must reside in West Virginia, maintain a satisfactory scholastic standing and demonstrate a real financial need. The limit per student is $500 per year. The loans are to be repaid within three years after graduation unless satisfactory evidence of hardship necessitates an extension of time for the repayment.

### Student and Faculty Apartments

President Elvis J. Stahr, Jr., recently announced plans for the construction of two student and two faculty apartments to be located near the Medical Center. This project will be financed by a bond issue and the revenue from rental fees will be used to pay the indebtedness. The apartments are part of a $5 million dollar housing program which is expected to be completed late this year or early in 1961.

A total of 124 efficiency and 40 one-bedroom units will be available in the two student apartment houses. All of the units will be completely furnished and will be used to house single and married students.

The faculty apartment houses will be located on the right side of the entrance to the Medical Center just off University Avenue. The two and three-bedroom apartments will be used by the faculty for a limited time until permanent private housing can be obtained.

The buildings are to be finished in a light grey brick, similar to that used in the Basic Sciences Building and the Teaching Hospital. It is planned to have the apartments ready for occupancy by next January.

### Miscellaneous

Forty-three first-year and 35 second-year students were enrolled in the School of Medicine for the second semester beginning in January. Eighteen students were enrolled in Medical Technology, nine in the first-year class and nine in the second-year class.

* * * *

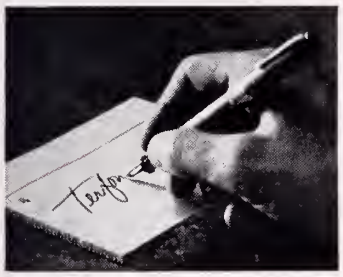
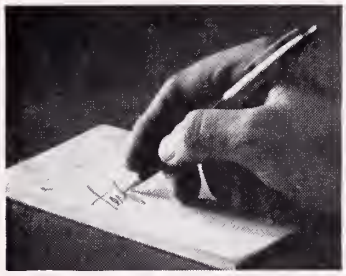
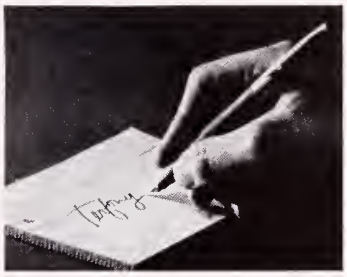
Dean E. J. Van Liere and Dr. Kenneth E. Penrod attended the 56th Annual Congress on Medical Education and Licensure which was held in Chicago, February 6-9. The Congress is sponsored by the Council on Medical Education and Hospitals of the American Medical Association, the Advisory Board for Medical Specialties and the Federation of State Medical Boards of the United States.

* * * *

The School of Medicine recently became affiliated with the Medical Education for National Defense Program which is sponsored and supported by the Department of Defense. The School became eligible for this program on the basis of the approaching expansion of the medical curriculum to a four-year program; and, in so doing, joins 70 other medical schools in this program.

Dr. Daniel T. Watts, professor of pharmacology, is serving as coordinator and is working with Dean Edward J. Van Liere during the initial stages of instituting the program.

The purpose of the MEND program is to incorporate into the existing curriculum and teaching programs, significant aspects of military and disaster medicine; to work toward creating an awareness on the part of the student and of the faculty responsibility of medical citizens in this period of international instability; to awaken in the participants a greater awareness of Federal educational research and vocational opportunities in the medical field.

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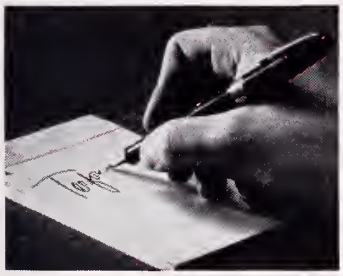

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# The Month in Washington

CONGRESS appears headed for a showdown this session on legislation for the Federal government to provide medical care for aged persons. The medical profession and allied groups stepped up their activities in opposition to such legislation as indications mounted that the issue was approaching a critical stage. Several State Medical Societies planned to send delegations to Washington to express personally their opposition to the proposed legislation.

The Eisenhower Administration announced it was working on three possible programs for providing health care for aged persons in cases of catastrophic—lengthy and costly—illness.

Without amplification, President Eisenhower told a news conference that there was under consideration "a possible change" in the Social Security Act "to run up the taxes by a quarter of a per cent to . . . make greater provision for the care of the aged." The President's statement that "there has been no conclusion reached in the administration" was backed up in a clarifying annnouncement by Arthur S. Flemming, Secretary of Health, Education and Welfare.

Flemming said his department was working on two other approaches to what he called a serious problem in addition to the possible revision of the Social Security law mentioned by Mr. Eisenhower. The HEW Secretary said consideration also was being given to: (1) stepped-up Federal assistance under the Federal-State public assistance program, and (2) the Federal government supplementing voluntary insurance programs.

Flemming again expressed opposition to the Forand Bill which would increase Social Security taxes by one quarter of one per cent each on employers and employes to provide hospitalization, surgical benefits and nursing home care for Social Security beneficiaries. The Secretary said he wanted to "underline that the position of the administration is opposition to the Forand Bill."

Flemming said he hoped to have an administration bill ready to submit in early April to the House Ways and Means Committee where the Forand Bill is pending. The Committee is scheduled to take up in late March or early April proposed changes in the Social Security Act.

Proponents of the Forand Bill—which is vigorously opposed by the American Medical Association and allied groups—were pointing their campaign toward securing the House Committee's approval of the legislation at that time.

• **From the Washington Office of the American Medical Association.**

The AFL-CIO, a main supporter of the Forand Bill, urged labor union members to write to congressmen on the Committee urging them to vote for it. The AFL-CIO also distributed a pamphlet quoting a handful of physicians as supporting the legislation. But the labor organization didn't mention that the overwhelming majority of doctors oppose it.

### McNamara Committee Reports

The Senate Subcommittee on Problems of the Aged and Aging, headed by Sen. Pat McNamara (D., Mich.), issued on behalf of its Democratic majority a report stating that use of the Social Security program "is the most efficient procedure for providing" health care for older persons.

The AMA and the Subcommittee's Republican minority promptly disputed this conclusion. An AMA statement issued in Chicago said:

"The American Medical Association today sharply disagreed with the recommendation of the McNamara subcommittee regarding government medicine for Social Security beneficiaries.

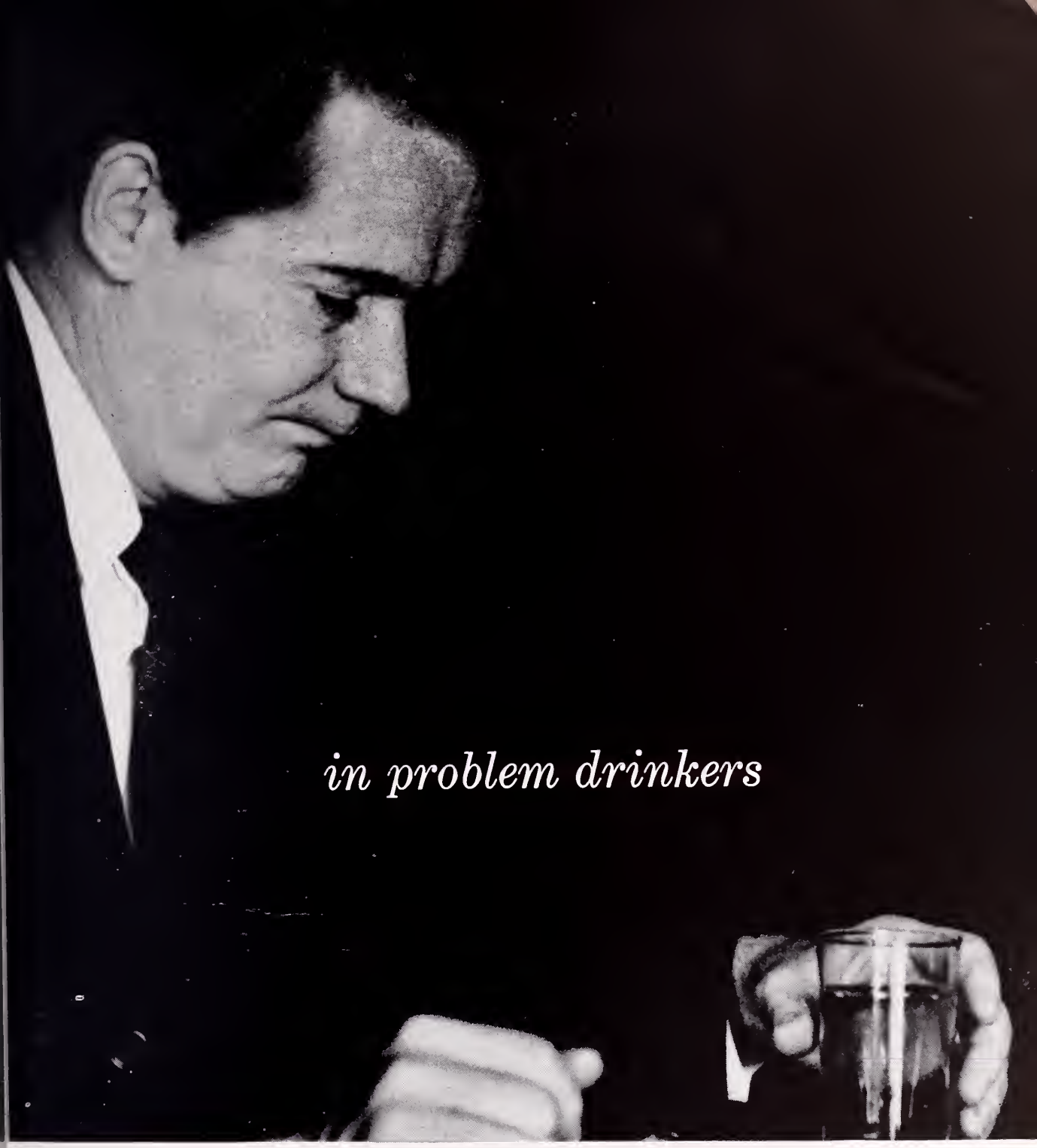
"Dr. Louis M. Orr, Orlando, Florida, President of the AMA said:

" 'This is a politically inspired committee. Senator McNamara, Democrat from Michigan, has long supported political medicine. The fact is that at the seven subcommittee hearings held throughout the United States, observers heard little support expressed by the older citizens who attended the hearings for government medicine financed by additional taxes and administered through Social Security.' "

The Republican minority stated that testimony before the Subcommittee "proves that it is possible for elderly people to secure private insurance to provide hospitalization and surgical benefits without any intervention by public authorities."

### Kennedy Introduces 'Health' Bill

Sen. John F. Kennedy (D., Mass.), a leading contender for the Democratic nomination for President, introduced legislation similar to the controversial Forand Bill but broader in scope. The Kennedy Bill would eliminate surgical benefits but would add diagnostic outpatient and home nursing services.





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# Obituaries

### GEORGE PRESTON DANIEL, M. D.

Dr. George Preston Daniel, 92, of Glen Daniel, Raleigh County, died in a hospital in Beckley on January 20, 1960. He had been ill for several months, and death followed complications after surgery.

Doctor Daniel was born at Cold River, October 24, 1868, son of the late Mr. and Mrs. Jesse Daniel.

After teaching school for several months, he enrolled in the University of Louisville School of Medicine and received his M. D. degree there in 1893. He located at Glen Daniel and began the practice of medicine the day after he received his degree.

He was always active in civic and political affairs of his community and enjoyed the distinction of being the first presidential elector from Raleigh County. As such, he cast a vote for Theodore Roosevelt in 1904.

At the time of his death, he had substantial business interests in Raleigh and Wyoming County.

He was an honorary member of the Raleigh County Medical Society, the West Virginia State Medical Association and the American Medical Association.

His wife, the former Nettie May Callaway, died in 1957. He is survived by two sons, Drs. Doff D. and Ross P. Daniel, both of Beckley. Three of his grandsons also are doctors, Doff D., Jr., who is located in Beckley, John Morton of Wichita, Kansas, and Richard of Philadephia.

### CHARLES W. PETTY, M. D.

Dr. Charles W. Petty, 93, of Atlanta, Georgia, died at the home of his daughter, Mrs. A. B. Ginden, in that city, February 5, 1960. At the time of his death he was the second oldest member of the West Virginia State Medical Association, the oldest being Dr. J. L. Cunningham of Pickens, who will be 97 years of age on September 1, 1960.

Doctor Petty was born in Wood County, West Virginia, September 19, 1866. He received his M. D. degree in 1893 from the College of Physicians and Surgeons, Baltimore. He served for a quarter of a century as a B. & O. surgeon, and also held office for several years as postmaster at Hartford. Doctor Petty engaged in practice in his home community until his retirement in 1948. He moved to Atlanta that same year, and lived there with his daughter until his death.

Doctor Petty was an honorary member of the Mason County Medical Society and served as its president in 1947. He was also an honorary member of the West Virginia State Medical Association and the American Medical Association.

Besides his daughter, he is survived by a grandson, Charles B. Ginden, and several nieces and nephews.

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**Surgery:**
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**Gynecology and Obstetrics:**
RAYMOND W. CRONLUND, M. D.

**Internal Medicine:**
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

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CORA C. LENOX, M. D.

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S. D. WU, M. D.

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# County Societies

### CABELL

The regular monthly dinner meeting of the Cabell County Medical Society was held on January 14 in the Georgian Terrace Room of the Hotel Frederick in Huntington, with the president, Dr. John F. Morris presiding.

Doctor Morris thanked the officers and members of the Society for their cooperation during the past year and urged support for the incoming president, Dr. I. Ewen Taylor. He then formally handed the gavel to Doctor Taylor.

Replying to the remarks by Doctor Morris, the new president outlined plans for the coming year, emphasizing particularly the many vexing problems arising from the Blue Cross situation, the Forand Bill and socialized medicine.

Dr. Edith Cserny, a member of the staff of the Huntington State Hospital, was unanimously elected to membership.

The Society voted the continuation of a $10.00 assessment for the annual Symposium.

Congressman Ken Hechler was to have been the speaker at the meeting, but was unable to attend.

A sound motion picture featuring Dr. Louis M. Orr, president of the AMA, was shown the members. It dealt exclusively with the dangers of the enactment of the Forand Bill.—W. L. Neal, M. D., Secretary.

* * * *

### FAYETTE

Dr. Joseph Berlow, a member of the staff of Laird Memorial Hospital, Montgomery, was the guest speaker before the regular monthly meeting of the Fayette County Medical Society at the White Oak Country Club, Oak Hill, on February 3, 1960. His subject was, "Radiant Energy and its Effects on the Eye."

At the business meeting following the scientific program the members went on record unanimously as being opposed to H. B. 47 relating to the licensing of foreign graduates, and a wire expressing the views of the Society was sent to Mr. W. T. Brotherton, Chairman of the House Committee on the Judiciary.

It was announced that the Society and the Woman's Auxiliary will meet in joint session in March.

Dr. Thomas C. Sims, the president, presided at the meeting, which was attended by ten members.—Marvin Kirsh, M. D., Secretary.

* * * *

### McDOWELL

The regular monthly dinner meeting of the McDowell County Medical Society was held at Grace Hospital in Welch on January 20, with the vice president, Dr. Guy E. Irvin presiding.

The following nominations of officers for 1960 were submitted by Dr. Freeman L. Johnston, chairman of the nominating committee, and all of those nominated were unanimously elected:

## OFFICERS OF COMPONENT SOCIETIES

| Society | President | | Secretary | | Meetings |
|---|---|---|---|---|---|
| Barbour-Randolph-Tucker | Samuel C. Johnson | Parsons | Charles L. Leonard | Elkins | 3rd Thurs. |
| Boone | James M. Scott | Madison | H. H. Howell | Madison | 2nd Wed. |
| Braake | James E. Wise | Fallansbee | H. L. Hegner | Wellsburg | |
| Cabell | I. Ewen Taylor | Huntington | W. L. Neal | Huntington | 2nd Thurs. |
| Central West Virginia | John E. Echols | Richwood | Jone Freeman | Buckhannon | As Scheduled |
| Eastern Panhandle | George F. Pugh | Martinsburg | F. A. Hamilton, Jr. | Martinsburg | Quarterly |
| Fayette | Thomas C. Sims | Longacre | Marvin Kirsh | Montgomery | 1st Wed. |
| Greenbrier Valley | E. T. Cabb | Ranceverte | James Hamilton | Marlinton | 2nd Wed. |
| Hancock | George Naymick | Weirton | Arthur Phillips | Weirton | 2nd Tues. |
| Harrison | Richard V. Lynch, Jr. | Clarksburg | Andrew J. Weaver | Clarksburg | 1st Thurs. |
| Kanawha | Milton J. Lilly | Charleston | A. B. Curry Ellison | Charleston | 2nd Tues. |
| Logan | Ray M. Kessel | Logan | Luke Combs | Man | 2nd Wed. |
| Marion | J. David Lindsay, Jr. | Fairmont | G. Thomas Evans | Fairmont | Last Tues. |
| Marshall | H. B. Ashworth | Maundsville | J. W. Myers | Maundsville | Semi-Ann. |
| Mason | C. Leonard Brown | Pt. Pleasant | Dan Glassman | Pt. Pleasant | |
| McDowell | Guy E. Irvin | Welch | George L. Fischer | Welch | 2nd Wed. |
| Mercer | W. E. Copenhaver | Bluefield | John J. Mahood | Bluefield | 3rd Mon. |
| Mingo | Frank J. Burian | Williamson | Russell A. Solton | Williamson | 2nd Thurs. |
| Monongalia | David Z. Morgan | Morgantown | C. A. Logue | Morgantown | 1st Tues. |
| Ohio | L. A. Lyon | Wheeling | Robert W. Leibold | Wheeling | 4th Tues. |
| Parkersburg Academy | Jack J. Stark | Belpre, Ohio | Robert M. Biddle | Porkersburg | 1st Thurs. |
| Potomac Valley | P. R. Wilson | Piedmont | H. L. Eye | Franklin | 2nd Wed. |
| Preston | John F. Lehmon | Kingwood | C. Y. Moser | Kingwood | 4th Thurs. |
| Raleigh | F. Vivan Lilly | Beckley | Prestan C. Davis | Beckley | 3rd Thurs. |
| Summers | Jack D. Woodrum | Hinton | A. W. Holmes | Hinton | 3rd Wed. |
| Taylor | R. D. Stout | Grafton | Herbert N. Shones | Grafton | Last Thurs. |
| Wetzel | Lemoyne Coffield | New Martinsville | C. P. Watson, Jr. | New Martinsville | Monthly |
| Wyoming | E. M. Wilkinson | Pineville | R. E. Newman | Mullens | Quarterly |

President, Dr. Guy E. Irvin; Vice President, Dr. Louis A. Vega; Secretary, Dr. George L. Fischer; Treasurer, Dr. Odis Glover; Board of Censors, Drs. A. A. Carr, Dante Castrodale and J. H. Murry; Delegates to the House of Delegates, Drs. A. J. Villani, R. H. Edwards and J. H. Burke; and Alternates, Drs. F. L. Johnston, Dante Castrodale and George L. Fischer.

It was announced that Dr. Theodore H. Boysen, III, and Dr. W. W. Currence, both of Charleston, were to have been the guest speakers at the meeting, but that they could not make the trip to Welch because of inclement weather.

Doctor Irvin announced the appointment of Drs. George L. Fischer, Kenneth N. Byrne, and Dante Castrodale, all of Welch, as members of the program committee for 1960.

The February meeting of the Society will be held at the residence of Dr. Dante Castrodale in Welch.—Louis A. Vega, M. D., Secretary.

* * * *

### MERCER

A joint meeting of the Mercer County Medical Society and the Mercer County Bar was held at the University Club in the West Virginian Hotel in Bluefield on January 18, 1960.

The guest speakers were Dr. W. F. Hillier, Jr., of Bluefield, and Honorable John A. Field, Jr., Judge of U. S. District Court for the Southern District of West Virginia. Doctor Hillier discussed the duties of physicians as witnesses, and the theme was elaborated upon by Judge Field.—John J. Mahood, M. D., Secretary.

* * * *

### PARKERSBURG ACADEMY

Dr. Richard S. Griffith of Indianapolis, Indiana, was the guest speaker at the regular monthly meeting of the Parkersburg Academy of Medicine which was held at the American Legion Home in that city on February 4.

Doctor Griffith, who is an associate in medicine at the University of Indiana School of Medicine and who is also associated with Eli Lilly and Company, presented an interesting paper on antibiotics. He said that antibiotics are far from being safe drugs and must be used with the full exercise of professional judgment.

He said the choice of an antibiotic depends upon the type of germ involved and the severity of the infection, together with the condition of the patient.

Dr. Jack J. Stark, the president, presided at the meeting which was attended by more than sixty members, interns and students from St. Joseph's Hospital School of Nursing.—Robert M. Biddle, M. D., Secretary

### Habit

Habit is habit and not to be flung out the window by any man, but coaxed downstairs a step at a time.—E. S. Weaver, M. D., in Journal, Kentucky State Medical Association.


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*Second Vice President:* Mrs. Myer Bogarad, Weirton
*Third Vice President:* Mrs. John F. Morris, Huntington
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*Treasurer:* Mrs. George A. Curry, Morgantown
*Recording Secretary:* Mrs. Rupert W. Powell, Fairmont
*Corresponding Secretary:* Mrs. James W. Hamilton, Marlinton
*Parliamentarian:* Mrs. J. Preston Lilly, Charleston

### HANCOCK

Dr. James L. Thompson, Medical Director of the Weirton Steel Company, was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Hancock County Medical Society, which was held at the Weirton Community Center in that city on January 26.

Doctor Thompson acknowledged appreciation on behalf of the medical staff of the Weirton General Hospital for the sponsorship of the Medical Library by the Woman's Auxiliary.

He emphasized the importance of an adequate and up-to-date medical library in the accreditation program of the hospital. He said that both the Hancock County Medical Society and the medical staff of the hospital desires to share in the maintenance of the medical library to assure its continuing progress.

Mrs. Richard A. Rose discussed plans for the spring meeting of the Executive Board of the State Auxiliary which will be held in Weirton, April 19-20.—Mrs. Roy G. Conrad, Correspondent.

* * * *

### HARRISON

Mrs. W. G. Merrells of Bridgeport reviewed the book, "The Life of Sir Alexander Fleming," before the dinner meeting of the Woman's Auxiliary to the Harrison County Medical Society held at the Stonewall Jackson Hotel in Clarksburg on February 4.

In her review, Mrs. Merrells revealed the hardships and constant struggling experienced by Doctor Fleming in the discovery of pencillin.

Special guests included the wives of physicians from throughout the state who were attending the "West Virginia Day Observance" of the Society.

Mrs. Walter H. Gerwig was welcomed as a new member of the Auxiliary.

Mrs. James A. Thompson, the president, presided at the meeting, which was attended by 50 members and 42 guests.—Mrs. Paul E. Gordon, Correspondent.


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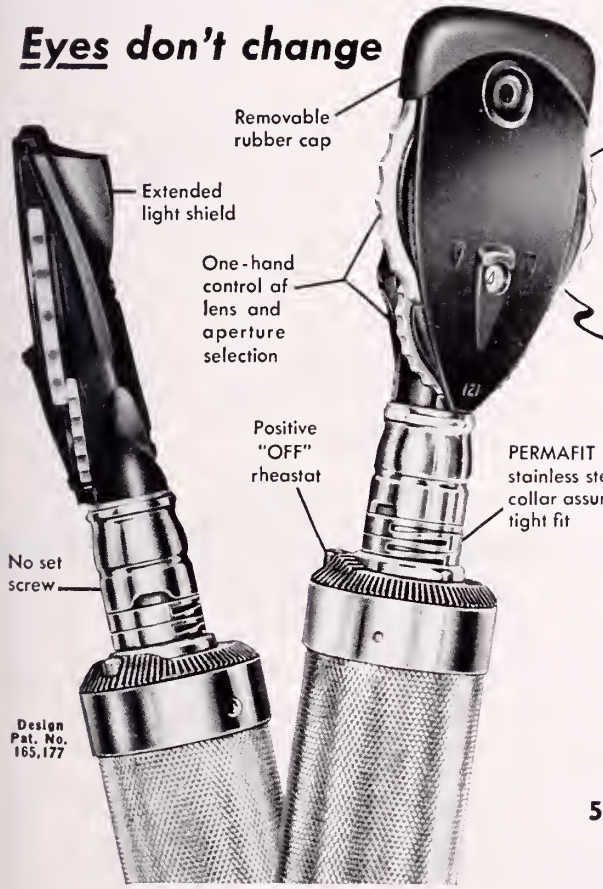


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**KANAWHA**

Mrs. A. C. Chandler reviewed Paul Gallico's "Mrs. 'Arris Goes to Paris" before the regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society at Humphreys' Dairy Bar in Charleston on February 9. She also presented thumbnail sketches of several current books.

Mrs. George Miyakawa, the president, presided at the meeting and Mrs. A. A. Wilson was chairman of the hostesses.

Guests present included Mesdames Wade Fleetwood, Ott Mathes, Paul Hall, W. J. Foster and Willard Smith —Mrs. W. W. Currence, Correspondent.

* * * *

**MONONGALIA**

The regular monthly dinner meeting of the Woman's Auxiliary to the Monongalia County Medical Society was held at the Hotel Morgan in Morgantown on February 2, with Mrs. Quin F. Curtis, school psychologist of Morgantown, as the speaker. Her subject was "Special Classes for Special Children."

Mrs. Curtis pointed out that the public school must provide an education for most children. She said that the state provides institutional care for some physically and mentally handicapped children, and maintains the school for the deaf and blind at Romney and the school for retarded children at St. Marys.

Mrs. Hubert Shaffer, the president, presided at a brief business session following the scientific program.

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Hostesses for the occasion were Mesdames C. C. Romine, H. V. King, G. R. Maxwell and Fred R. Whittlesey.—Mrs. H. T. Marshall, Correspondent.

* * * *

### OHIO

The regular monthly luncheon meeting of the Woman's Auxiliary to the Ohio County Medical Society was held at the Wheeling Country Club on January 28.

Mrs. David Wiles, Director of Volunteer Services at the Ohio Valley General Hospital, discussed types of volunteer services and stressed the need for additional workers.

Mr. John Randolph, Manager of the AAA of Wheeling, presented an interesting paper on the subject of "The United Nations."

Hostesses for the meeting were Mesdames Francis Gaydosh, chairman, Howard T. Phillips, Jr., S. S. Bobes, William Perilman, John P. Young, and Daniel W. Dickinson.—Mrs. R. S. Robbins, Correspondent.


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# *Book Reviews*

**THE CIGARETTE HABIT: A SCIENTIFIC CURE—By Arthur King. Pp. 96. Doubleday and Company, Inc., 575 Madison Avenue, New York 22, New York. 1959. Price $2.00.**

This little 96-page book tells you how "you can now break the cigarette habit easily, effectively and without discomfort." It defines a psychological attack on the cigarette habit and makes good reading for addicts and anti-tobacco crusaders.

The author, among other attainments, is "consultant in alcohol problems" and decided to take the cigarette addicts under his protection and provide them with a formula for escape from their addiction.

In a personal attempt to terminate his cigarette habit abruptly, the author found that the first 24 hours were pure unmitigated hell. He suffered with extreme and acute anxiety, anorexia, tremors, swelling of the hands and feet, nausea and vomiting and a sudden desire to get drunk. He found that others suffered the same complaints in their abrupt withdrawal, so he developed a formula for withdrawal that in his experience has been found to be painless and devoid of major complaints. The reviewer has removed many patients from their cigarette habits and has yet to see a patient experience the discomfort of the alcohol or drug addict to withdrawal.


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**Thoracic Surgery:**
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**Obstetrics and Gynecology:**
Robert W. Leibold, M. D.
Robert T. Brondfass, M. D.

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**Neurological Surgery:**
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Frank M. Hudson, M. D.

**Internal Medicine:**
William M. Sheppe, M. D.
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

**Neurology and Psychiatry:**
Albert L. Wanner, M. D.

**Roentgenology:**
William K. Kalbfleisch, M. D.

**Clinical Laboratories:**
Ann B. Charleton, M. T.

**Technologists:**
Electrocardiology:
Joan Vensel, R. N.
Electroencephalography:
JoAnn Hastings
Roentgenology:
Evelyn Forester, R. T.

**Business Administration:**
John H. Clark, Manager
Lester L. Cline, Ass't. Bus. Mgr.

The author divides his smokers into four groups a day. The light smoker who consumes 5-15 cigarettes per diem and comprises 5 to 7 per cent of smokers. The medium smoker who uses about a pack per day and who quits readily and relapses promptly. The heavy smoker who uses 20 to 30 cigarettes daily and quits with some difficulty, and there is the cigarette addict, who regardless of the amount of smoking, contemplates withdrawal with the utmost horror. The book contains check lists that will enable the smoker to find his proper category.

The system is elaborate in detail and must be followed with precision. The program begins 21 days before Q-Day or Quitting Day. From Q-Day to Q-21, there is something to do almost every hour. The author makes liberal use of Flavettes, and uses some phenobarbital, caffeine and dexedrine.

The 25 virtues to be gained by withdrawal listed on pages 61 and 62 should convince any hard-bitten addict that the attempt is worth the effort.

Chapter 4 is devoted to the claims of the American Cancer Society concerning the unhealthy effects of cigarette smoking and also to the explanations and counter claims of the Tobacco Industry Research Committee. The author comes up with two hypotheses:

1. Some smokers of cigarettes differ qualitatively from other smokers in that they exhibit "addictive behavior in reference to smoking."
2. Addicted smokers, if such exist, are probably more susceptible to lung cancer, coronary heart disease, and other diseases than are non-addicted smokers.

The author states it is his firm conviction that the addictive smoker ought to quit smoking right now and wishes to have all "cures" mail to him the date sheets that are kept during the withdrawal period. He further states that except for the unfortunate few who have become addicted, "tobacco smoking, including cigarette smoking, is a boon and not a threat to human life and society."

Critical readers, especially physicians concerned with the health hazard of cigarette smoking, will find this categorical division of smokers unacceptable.

The statement that cigarette smoking is a boon to human life and society but that when you cross the invisible line of addiction you thereby increase your susceptibility to cancer is contradictory and totally incompatible.

To those who wish to quit the cigarette habit, addicts or not, this little book may be very helpful. This reviewer, a firm believer in the reports of the American Cancer Society and the USPHS and the oft repeated admonition of his grandmother to stay away from those coffin nails, thoroughly recommends the formula to all those who, weak in spirit, require a psychological prop to bolster their good intentions.

* * * *

**DOCTOR STRAND—By Boris Sokoloff, M. D., Director of the Southern Bio-research Institute, Florida Southern College, Lakeland, Florida. Pp. 205. Vantage Press, Inc., 120 W. 31st St., New York 1, New York. 1960. Price $3.50.**

This little volume is a fictional discussion of cancer research and of the individuals conducting the re-


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search. The style is entertaining—exceptionally so to a layman—for a book with scientific research background. The English is to all intents and purposes perfect, certainly as good as that of an author whose mother tongue is English.

The difficulties encountered in research, and especially in seeking a chemotherapeutic agent for the cure of cancer, are well portrayed and one is sadly disappointed when TEK-Thirteen is found to be too toxic for use in the human being.

The foul-smelling feature of the book is the moral laxity of the researchers and their wives. While the author may not have intended it, the violation of the Seventh Commandment stands out as prominently, at least in the eyes of this reviewer, as does the devotion to cancer research and the longing for the development of an actual cure for neoplastic disease.

We would readily admit that promiscuity is apparently more widespread than in the Victorian era, but we doubt that it is as prevalent among research groups as Doctor Sokoloff portrays in this book. Despite the recent press reports about a murder in the research staff of a great southern university, we believe in the integrity of the research group in America both scientifically and morally. In our eyes they are "the cream of the crop" as far as scientific advance and human betterment are concerned. Certainly those whom we know have impressed us with their morality, their outstanding sincerity, their devotion to the advancement of knowledge and to the betterment of human kind.—Walter E. Vest, M. D.

## Books Received

**THE RELUCTANT SURGEON**—By John Kobler, Wilton, Connecticut. Pp. 359. Doubleday and Company, Inc., 575 Madison Avenue, New York 22, New York. 1960. Price $4.95.

* * * *

**DRUGS OF CHOICE 1960-1961**—By Walter Modell, M. D., Director, Clinical Pharmacology, and Associate Professor of Pharmacology, Cornell University Medical College; Attending Physician, New York Veterans Administration Hospital; Associate Visiting Physician, Bellevue Hospital; Member, Poison Control Advisory Board of New York City; Member, Revision Committee, United States Pharmacopeia XVI; and Editor, Clinical Pharmacology and Therapeutics. Pp. 958. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Missouri. Second Edition. 1960. Price $13.50.

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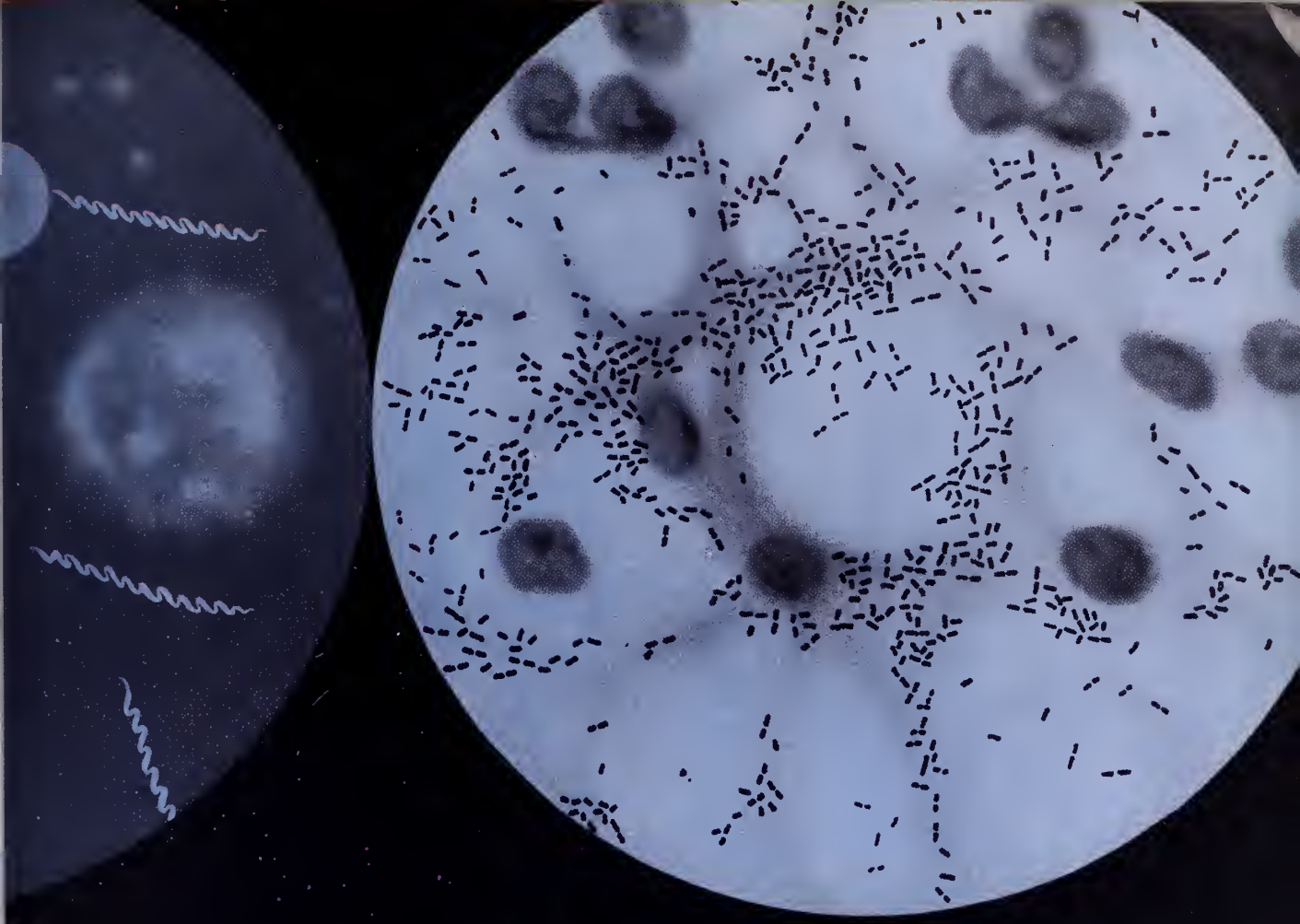

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*rences:* (1) Morton, J. J.: *Yale J. Biol. & Med.* **31**:397, 1959. (2) Rogers, D. E., & Louria, D. B.: *New England J. Med.* **261**:86, 1959. eming, B. H., Jr., & Flanigan, C., Jr., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclo- , Inc., 1959, p. 414. (4) Edwards, T. S.: *Am. J. Ophth.* **48**:19, 1959. (5) Olarte, J., & de la Torre, J. A.: *Am. J. Trop. Med.* **18**:324, 1959. ater, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* **9**:38, 1959. (7) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* **30**:175, 1958.

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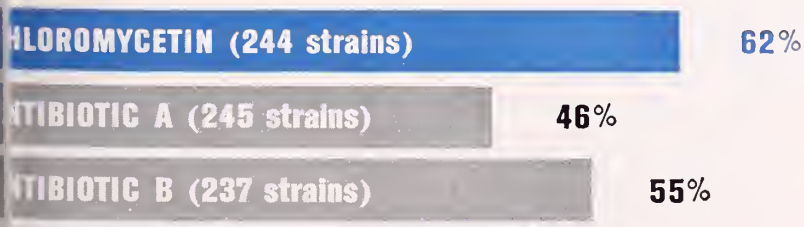


*Adapted from Leming & Flanigan.[9]

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APRIL
1960

Vol. 56 No. 4

# The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone Dickens 4-4625.

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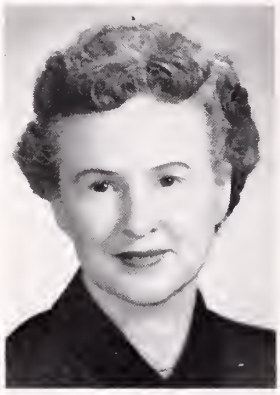
# WVU Medical Center
# —News—

Miss Audrey E. Windemuth, who assumed her duties as Director of the Nursing Service at the WVU Teaching Hospital on February 1, has initiated an active recruiting program to obtain a staff for the opening of the nursing section of the hospital.



Miss Windemuth

She announced that general nursing policies are being prepared both for the in-patient and out-patient sections of the hospital. It is hoped that certain key nursing personnel will be appointed within the next two months, as it will be necessary to establish in-service orientation and training programs for nursing personnel in the specialized areas of the hospital.

A contract to supply room furniture for 200 patient units in the Teaching Hospital has been awarded to the Hill-Rom Company. On March 15, contracts and purchase orders were issued for the majority of heavy capital equipment for the operating rooms, out-patient department laboratories, x-ray and public areas. The purchase of this equipment will involve an expenditure of approximately $500,000. Delivery has been set for June 1.

### Medical Center Lecture Series

A lecture series has been instituted at the Medical Center during the second semester. The purpose of the series is to present to the entire student body and faculty outstanding authorities on various subjects.

During the month of February, lectures were presented by Dr. Kenneth E. Penrod, Vice President-Medical Affairs, and Dr. Claud Fraleigh, professor of periodontology, WVU School of Dentistry. Doctor Penrod discussed the development of the WVU Medical Center, and the subject of Doctor Fraleigh's paper was "Brain Washing as Practiced by the Chinese Reds."

Doctor Fraleigh, a prisoner of the Japanese for approximately four years during World War II, and who later was attached for several months to a Russian Tank Unit, served on the repatriation team at the conclusion of the Korean War.

He said the Chinese did a masterful job of applying psychological and psychiatric principles to American prisoners captured during the Korean conflict and, at least during the time of imprisonment, they were highly successful as compared to any previous attempts to influence the thinking of American soldiers.

• **Compiled from material furnished by John B. Horley, M. D., Assistant Professor of Pathology and Public Information Officer at the WVU Medical Center in Morgantown, W. Va.**

Dr. Frank M. Mateer, a member of the faculty at the University of Pittsburgh School of Medicine, delivered a paper on March 11 on the subject of "Acute Renal Failure and the Role of the Artificial Kidney." On March 18, Dr. Francis Jackson, Chief of Surgery at the VA Hospital in Pittsburgh, presented a paper on "Cancer Chemotherapy as an Adjunct to Surgery."

### Acceptances Mailed to Prospective Students

Dr. Clark K. Sleeth, Assistant to the Dean and Chairman of the Admissions Committee, announced that acceptances have been mailed to 46 prospective first-year students for the term beginning in September. In addition, two alternates were named.

The students are all residents of West Virginia and they represent 21 counties. Cabell and Monongalia counties each are represented by six students; Kanawha, Mercer and Marion by four; McDowell and Mingo by three; Greenbrier, Logan and Nicholas by two; and one each from Barbour, Berkeley, Boone, Brooke, Hancock, Harrison, Marshall, Mineral, Raleigh, Roane, Upshur and Wyoming.

The students have varied educational backgrounds. Nineteen did the majority of their undergraduate work at West Virginia University; six at Marshall College, five at Wheeling College, three at West Virginia Wesleyan College, and one each at Virginia Polytechnic Institute, Berea College, West Virginia State College, Miami University (Ohio), Morris Harvey College, University of Texas, University of Virginia, Shepherd College, Marietta College, Concord College, Alderson-Broaddus College, University of Alabama, Wake Forest College, University of Cincinnati, and the University of Michigan.

### School of Medicine Receives Grant

The School of Medicine has been awarded a $9,900 grant by the Army Quartermaster Food Container Institute to support a study of the physiology and metabolism of the spores of Clostridum botulinum by Dr. W. Knox Harrell, associate professor of microbiology.

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# The Month in Washington

CONGRESS has been warned against acting on legislation to provide health care of the aged before receiving the recommendations of next year's White House Conference on Aging.

Rep. Noah M. Mason (R., Ill), ranking minority member of the House Ways and Means Committee which handles this type of legislation, put in the Congressional Record an exchange of correspondence with former Rep. Robert W. Kean (R., N. J.), Chairman of the National Advisory Committee supervising preparations for the White House Conference next January.

Rep. Mason said the correspondence "reveals the reason why Congress should await the results of the Conference."

"Let us not waste the $2 million we have already appropriated to bring thousands of good minds together to suggest solutions to problems of our aging population," Rep. Mason said. "Certainly we should get the benefit of their advice rather than enact legislation in haste and without proper study."

Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association, also voiced this warning in a radio interview while he was in Washington for conferences with White House aides and Arthur S. Flemming, Secretary of Health, Education and Welfare.

Dr. Blasingame said that it would be "neither practical nor realistic" for Congress to act on such legislation until the White House Conference and other sources had compiled "more conclusive and complete information" on a nationwide basis.

Dr. Blasingame and other AMA representatives emphasized to President Eisenhower's aides and Flemming that the medical profession is unalterably opposed to any legislation, such as the Forand Bill, that would use the Social Security system to provide health care for the aged.

In his letter to Mason, Kean predicted that "in all probability" most of the White House Conference's recommendations would be for "state and local activity" in dealing with the problems of the aged. Kean said that action at the state and local level "seems most effective."

The National Association of Manufacturers charged in a pamphlet that supporters of Forand-type legislation have exaggerated the health care needs of the nation's older people. The NAM pamphlet also said the Forand Bill was an entering wedge for a cradle-to-grave compulsory health insurance plan.

• **From the Washington Office of the American Medical Association.**

### Brighter Prospects for Keogh-Simpson Bill

Elsewhere on the national legislative front, prospects brightened for Congressional passage this year of a bill to permit physicians and other self-employed persons to set aside money for retirement.

The Administration, which last year opposed a bill with such provisions, appeared in Mid-March to be ready to support it with modifications.

The Administration shift improved the already favorable odds that both the Senate Finance Committee, where a House-approved bill is pending, and the Senate will approve such legislation this session.

### Generic vs. Trade Names in Prescriptions

The issue of generic names vs. trade names in doctors' prescriptions came to the forefront in the Senate Monopoly Subcommittee's investigation of the drug industry.

Dr. Austin Smith, President of the Pharmaceutical Manufacturers Association, testified at a Subcommittee hearing that "behind brand names lie the reputation, reliability and skill of the manufacturer." He said use of generic terms would restrict a physician's choice as to drugs and would transfer some of the physician's responsibility to the pharmacist.

"By brand name prescription, the doctor orders for a patient a specific product in which he has absolute knowledge of quality, purity and any side effects that might have importance for a particular patient," Dr. Smith said.

Dr. R. B. Robins of Camden, Ark., who accompanied Smith at the hearing, submitted a similar statement. He said he used trade names because: "It is simpler to write such a prescription and I can be assured that no substitution will be made by the druggist—this assures me that the patient will get top quality."

Despite this testimony, Sen. Estes Kefauver (D., Tenn.), the Chairman of the Subcommittee, said he hoped physicians would give "serious thought" to use of generic terms. He contended that doctors thus could bring down drug prices by opening the way for small manufacturers to give the major companies "some good, honest, old-fashioned price competition."

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# Obituaries

### CHARLES NEWTON BROWN, M.D.

Dr. Charles Newton Brown, 91, who practiced medicine in West Virginia for 58 years, died February 20, 1960, at a hospital in Marietta, Ohio, following a brief illness.

Doctor Brown was born at Independence, Preston County, January 16, 1869, son of the late Dr. and Mrs. Ashford Brown.

He received his M.D. degree from the Hospital College of Medicine, Louisville, Kentucky, in 1894 and began the practice of medicine at Rivesville. He later located at Elizabeth, where he engaged in practice for 29 years. He also practiced for several years at Widen and Swandale.

Upon his retirement in 1952 he and his wife moved to Marietta.

He served as a Captain in the Medical Corps of the Army during World War I.

He was an honorary member of the Parkersburg Academy of Medicine, the West Virginia State Medical Association and the American Medical Association.

Besides his widow, the former Eva Dell Keane, he is survived by a daughter, Mrs. Evelyn Newart of Marietta.

### JAMES WOOD FRAZIER, M.D.

Dr. James Wood Frazier, 62, of Charleston, died in a local hospital on March 11, 1960, following a short illness.

Doctor Frazier was born in Greenville, Muhlenberg County, Kentucky, in 1897. He attended the University of Kentucky at Lexington and received his M.D. degree from the Medical College of Virginia in 1928. He interned at the C. & O. Hospital in Clifton Forge, Virginia, and had postgraduate work at Detroit EENT Hospital and New York Ophthalmic Hospital, 1932-33.

He was licensed in West Virginia in 1934 and located at Charleston, where he engaged in the practice of his specialty of ophthalmology and otolaryngology continuously until his death.

He was a former member of the Public Health Council (now Medical Licensing Board) and was a member of Kanawha Medical Society, the West Virginia State Medical Association, the American Medical Association and the West Virginia Academy of Ophthalmology and Otolaryngology.

Besides his widow, he is survived by a sister, Mrs. Harold Mitchell of Oxnard, California, and three brothers, Frank and Lewis Frazier of Greenville, Kentucky, and Dr. E. S. Frazier of Effingham, Illinois.

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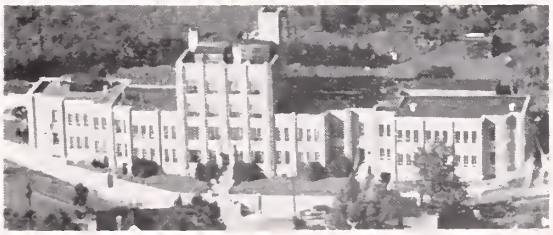
Nature has made two sorts of excellent intellects; one kind to produce beautiful thoughts or actions, the other to admire them.—Joseph Joubert.

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### JAMES EDWARD HUBBARD, M. D.

Dr. James Edward Hubbard, 71, formerly of Huntington, died in a hospital in Baltimore, Maryland, on February 23, 1960. Death followed an illness of several months' duration.

Doctor Hubbard was born in Caroline County, Maryland, December 24, 1888. He received his M. D. degree from the University of Maryland School of Medicine in 1908. Upon the completion of his internship at the Hinton Hospital, he located in that city for the practice of medicine. He had postgraduate work in dermatology at hospitals in New York City and in Vienna, Austria.

Doctor Hubbard moved to Huntington in 1920, where he continued the practice of his specialty of dermatology until his retirement in 1956. He moved to Baltimore that same year.

He served as a captain in the Medical Corps of the Army during World War I.

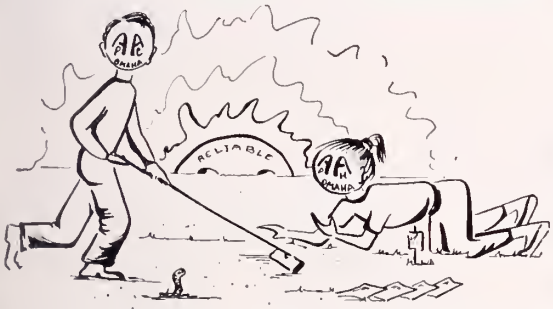
Doctor Hubbard was a former member of the Cabell County Medical Society, and had served a term as vice president. He was also a former member of the West Virginia State Medical Association and the American Medical Association.

He is survived by his widow, the former Elizabeth Powell, who resides in Baltimore.

* * * *

### WILLIAM B. MacCRACKEN, M. D.

Dr. William B. MacCracken, 53, orthopedic surgeon of Huntington, died at his home in that city on February 29, 1960.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Doctor MacCracken was born in Mt. Vernon, New York, February 9, 1907. He received his M. D. degree from the Columbia University College of Physicians and Surgeons, New York City, 1932, and interned at Bellevue Hospital, in that city, 1932-35. He served a residency in orthopedic surgery at New York Orthopedic Hospital, 1935-40. He was certified by the American Board of Orthopedic Surgery.

During World War II, he served in the Medical Corps of the Navy and was awarded the Navy Cross.

Doctor MacCracken located in Huntington in 1946 where he remained in active practice until his death.

He was a member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by his mother who resides in Huntington, and a daughter, Mrs. James Murphy of Emigrant, Montana.

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# County Societies

### CABELL

Dr. Richard L. Meiling of the Ohio State University Health Center, Columbus, was the guest speaker before the regular monthly meeting of the Cabell County Medical Society held in the Georgian Terrace Room of the Hotel Frederick in Huntington on February 11.

Doctor Meiling reviewed a three-year cancer detection and therapy survey conducted in the Columbus area. He said that Papanicolaou smears on a mass basis constitute a definite aid in the early detection of cancer of the genital tract. He said that proper early treatment offers a good chance for cure. He said also that the physician's office is the best cancer detection center.

At the business meeting following the scientific program, Dr. James A. Heckman submitted a report for the Blue Cross committee concerning the proposed consolidation of the Huntington and Charleston Blue Cross Plans. In the report, which was approved by the Society, it was emphasized that (1) the Charleston Blue Cross Plan is in sound financial condition; (2) consolidation is in the best interests of all concerned and is, indeed inevitable; and (3) consolidation is being carried out in an orderly and equitable manner.

The president, Dr. I. Ewen Taylor, presided at the meeting which was attended by 65 members.—W. L. Neal, M. D., Secretary.

* * * *

### FAYETTE

A joint dinner meeting of the members of the Fayette County Medical Society and Auxiliary was held at the Glen Ferris Inn in Glen Ferris on March 2, with the president, Dr. Thomas C. Sims, presiding.

The guest speaker was Dr. Roger P. Elser of Charleston, Supervisor of Special Education, Division of Instruction and Curriculum, State Department of Education. He discussed facilities available for diagnosis and education of children who are mentally deficient, blind, and who have speech or hearing defects.—Marvin Kirsh, M. D., Secretary.

* * * *

### McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held on February 15 at the home of Dr. and Mrs. Dante Castrodale in Welch.

Dr. George L. Fischer discussed a case of hyperparathyroidism, and Dr. Guy E. Irvin a case of Addison's disease. General discussion followed the presentation of the two papers.

The president, Dr. Guy E. Irvin, presided at the meeting which was attended by thirteen members and five guests.—George L. Fischer, M. D., Secretary.


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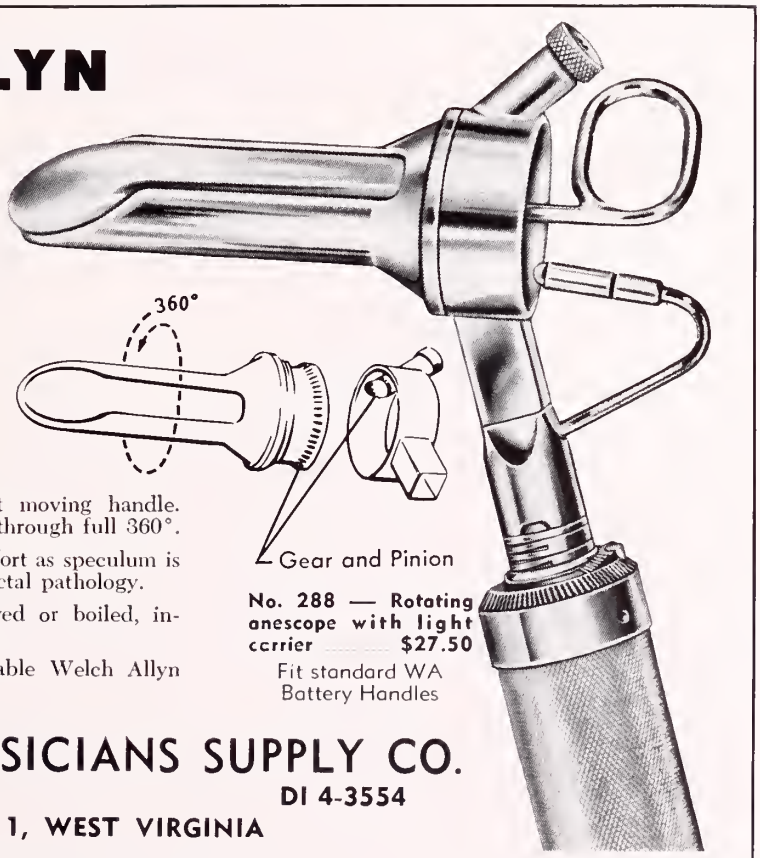


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### MONONGALIA

Dr. William B. Kiesewetter, Chief of Surgery at Children's Hospital in Pittsburgh, was the guest speaker at a meeting of the Monongalia County Medical Society which was held at the Hotel Morgan in Morgantown on March 1. His subject was "Tip-off to Trouble in the Newborn Infant."

Dr. David Z. Morgan, the president, presided at the business meeting which followed the scientific program. Drs. Frederick R. McKeehan and Carl H. Cather, Jr., were unanimously elected to membership in the Society.

Plans were discussed for a Tri-County Medical meeting, which will be held in Morgantown late in May. The meeting was attended by 33 members.—C. A. Logue, M. D., Secretary.

* * * *

### WYOMING

A joint dinner meeting of the Wyoming County Medical Society and Auxiliary was held at the Cow Shed in Pineville on March 6. Despite inclement weather, a large number of physicians and their wives attended the dinner, which was followed by a scientific program.

The speaker was Dr. Byron W. Steele of Mullins, who spoke on the subject of "Monilia Fungus Pneumonia. He presented a recent and typical case with x-ray follow-up studies, differential diagnoses and treatment. A question and answer period followed.—Ross E. Newman, M. D., Secretary.

## *Woman's Auxiliary*

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*Third Vice President:* Mrs. John F. Morris, Huntington
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*Recording Secretary:* Mrs. Rupert W. Powell, Fairmont
*Corresponding Secretary:* Mrs. James W. Hamilton, Marlinton
*Parliamentarian:* Mrs. J. Preston Lilly, Charleston

### NEW AUXILIARY IN SUMMERS

A new county auxiliary was organized within the Summers County Medical Society on February 20, 1960, at a meeting held at the home of Mrs. Jack D. Woodrum in Hinton.

Mrs. Woodrum was elected president and Mrs. D. W. Ritter, secretary-treasurer. They will serve during the current auxiliary year.

The number of auxiliaries in West Virginia now totals 23, local auxiliaries having been named within all but five of the county or multiple-county medical societies.


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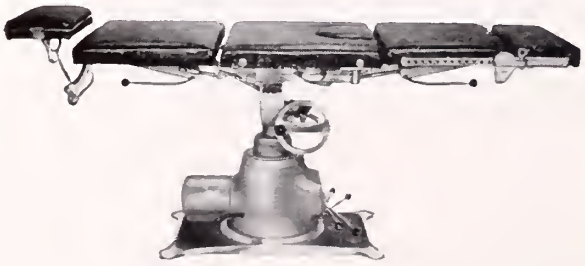

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### EASTERN PANHANDLE

The regular quarterly meeting of the Woman's Auxiliary to the Eastern Panhandle Medical Society was held at the Shenandoah Hotel in Martinsburg on February 10. Mrs. Curtis G. Power, the president, presided at the luncheon meeting.

The guest speaker was Robert Steptoe, Attorney of Martinsburg. His subject was "Wills and Estates," and a question and answer period was held following his address.

Hostesses for the luncheon were Mesdames Frank A. Hamilton, Jr., George F. Pugh, Jr., and N. B. Graves.

* * * *

### HARRISON

The members of the Woman's Auxiliary to the Harrison County Medical Society were hostesses at the annual observance of Doctors' Day which was in the nature of a smorgasbord and dance at the Stonewall Jackson Hotel in Clarksburg on Saturday evening, March 5, with more than 70 guests present.

Each member of the Society was presented with a red carnation, the official flower used in honoring physicians.

Movies were taken of the members and their wives present, and movies taken at previous doctors' day meetings were shown by Dr. R. T. Humphries.

Dr. and Mrs. James A. Thompson were hosts at a social hour preceding the dinner.


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James K. Stewart, M. D.

**Orthopedic Surgery:**
C. B. Buffington, M. D.

**Thoracic Surgery:**
Daniel W. Dickinson, M. D.

**Obstetrics and Gynecology:**
Robert W. Leibold, M. D.
Robert T. Brandfoss, M. D.

**Urology:**
Richard D. Gill, M. D.

**Neurological Surgery:**
James S. Rogers, M. D.
Frank M. Hudson, M. D.

**Internal Medicine:**
William M. Sheppe, M. D.
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacab, Jr., M. D.

**Neurology and Psychiatry:**
Albert L. Wanner, M. D.

**Roentgenology:**
William K. Kalbfleisch, M. D.

**Clinical Laboratories:**
Ann B. Charleton, M. T.

**Technologists:**
Electracardiology:
Joan Vensel, R. N.
Electroencephalography:
JoAnn Hastings
Roentgenology:
Evelyn Forester, R. T.

**Business Administration:**
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Lester L. Cline, Ass't. Bus. Mgr.

Arrangements for the dinner were made by a committee composed of Mrs. A. Robert Marks, chairman, and Mesdames Joseph Gilman, J. Keith Pickens, D. M. Robinson, R. V. Lynch, S. M. Markowitz and R. T. Humphries.—Mrs. Paul E. Gordon, Correspondent.

* * * *

### OHIO

The regular monthly meeting of the Woman's Auxiliary to the Ohio County Medical Society was held at the Fort Henry Club in Wheeling on February 23.

The speaker was Mr. Thomas B. Miller, prominent attorney of Wheeling, who discussed "Aspects of Law as Related to the Doctor."

A skit, "Questions and Answers on Legislation," was presented following Mr. Miller's address. Participants were Mesdames Robert T. Bandi, Andrew J. Niehaus and Francis J. Gaydosh.

Mrs. Joseph N. Aceto of Wheeling was welcomed as a new member of the Auxiliary.

A brief business meeting was held following the program, with the president, Mrs. John G. Thoner, presiding, and the following nominating committee was announced: Mrs. W. Carroll Boggs, Chairman, and Mesdames Francis J. Gaydosh, Andrew J. Niehaus, Harry S. Weeks, Jr., and George M. Kellas.

It was announced that the annual Doctors' Day Dinner will be held on March 26.—Mrs. Robert S. Robbins, Correspondent.

### PARKERSBURG ACADEMY

Mrs. Charles H. Barnett was elected president of the Woman's Auxiliary to the Parkersburg Academy of Medicine at a meeting held at the Chancellor Hotel in that city on March 8. Other new officers are as follows:

Mrs. George Gevas, president elect; Mrs. David B. Thornburgh, first vice president; Mrs. Charles W. Thacker, second vice president; Mrs. George E. McCarty, recording secretary; Mrs. Donald R. Lantz, corresponding secretary; and Mrs. Lawrence R. Leeson, treasurer.

Mrs. Edward Shupala, the retiring president, presided at the business meeting. Reports were presented by Mesdames Lyle D. Vincent, Lawrence R. Leeson, David B. Thornburgh and Michael A. Santer.

It was announced that the annual "Doctors' Day" observance will be held at the Worthington Golf Club on April 7.—Mrs. Donald R. Lantz, Correspondent.


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# Book Reviews

**THE EMERGENCY SYNDROMES IN PEDIATRIC PRACTICE —By Alfred J. Vignec, M. D., Clinical Professor of Pediatrics, New York University College of Medicine, New York City. Pp. 382, with illustrations. Landsberger Medical Books, Inc., 51 East 42nd Street, New York City. 1959. Price $9.00.**

This is a book which many clinicians will enjoy reading; it has large print, a pleasant format, and is not too heavy—either in weight of paper or in weight of information presented. This is evidently intentional on the part of the author who sets out a number of acute clinical situations which may require treatment before a diagnosis is readily available. He recommends treatment procedures as well as diagnostic steps to be taken. Often the treatment precedes the diagnostic steps. This is his aim as he states it in the preface and on the whole he succeeds.

Doctor Vignec writes in a way that will ring pleasantly in the ears of clinicians since he gives the impression that he has seen a large number of children and has been in the various situations which he describes. In fact he is at his literary best where he is describing problems he has had to cope with, especially where he illustrates these from his own experiences. This tends to enliven the book somewhat even though he does not give any exhaustive case histories. At times the material flows freely and smoothly and one obtains the impression that Doctor Vignec is very much at home dealing with the emergencies described. When quoting others he seems not nearly so assured.

Unfortunately the book suffers from a number of faults. There is inadequate editing as manifested by a number of mistakes including some rather significant omissions. For example in the very interesting discussion on convulsions there is a reference on page 229 to a table which the reviewer has been unable to find. On page 265 the attempt to simplify instructions for calculation of fluid and electrolyte requirements results in several errors. For example under Step 1-a the following equation appears:

(a). Fluid (4.5 Kilo X 150 ml.) 240 ml. (wt. loss) = 915 ml.

This equation will not balance unless a + sign is inserted to make the following formula:

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(a). Fluid (4.5 Kilo X 150 ml.) + 240 ml. (wt. loss) = 915 ml. In parts b, c. and d of the same step of the example it is not clearly indicated where the figures 14, 12 and 5 are obtained.

Another error, evidently an oversight, is listing $CO_2$ values in mg% on page 263. There are some spelling errors such as protein for protean on page 100.

As long as the author goes into the Laboratory diagnosis of acquired Hemolytic Anemia, mention of his opinion of the value of the Coomb's test on page 209 in this condition would seem appropriate.

The book would be improved by the inclusion of a section on methods of obtaining blood and methods of administering fluid along with appropriate illustrations. Comment on the management of acute head injury would make the book more complete.

Finally, one is forced to conclude that while this book is informative and easy to read it falls quite a bit short of its potential usefulness because of errors due to poor editing. This reviewer would be glad to see a revised edition issued.—Donald M. Burke, M. D.

* * * *

**CLINICAL AUSCULTATION OF THE HEART—By Samuel A. Levine, M. D., Clinical Professor of Medicine (Emeritus), Harvard Medical School and W. Proctor Harvey, M. D., Associate Professor of Medicine, Georgetown University School of Medicine. Pp. 657, with 660 illustrations. Second edition. Philadelphia and London: W. B. Saunders & Company. 1959. Price $11.00.**

The purpose of the book is excellently expressed in the preface in which the authors state, "It has become quite clear that a few minutes of intelligent auscultation of the heart can reveal many findings of vital importance. The value of the simple stethoscope is steadily increasing."

The contents are divided into four large chapters, Heart Sounds, Cardiac Irregularities, Cardiac Murmurs, and Miscellaneous Auscultatory Factors. The illustrations are composed of synchronous phonocardiograms and electrocardiograms, which are most instructive to all students in cardiology.

In the chapter on Cardiac Irregularities, the sections on many common irregularities are carefully discussed from an etiologic standpoint. The auscultatory findings are described and illustrated by appropriate phonocardiograms and electrocardiograms, with an interpretation of each, and many of the sections conclude with a chapter on treatment, which is precise and in minute detail. So the material is not confined to auscultatory description alone, but embraces etiology, diagnosis, therapy, and prognosis. Hence the book is much more inclusive than the title indicates.

There is a long chapter on Cardiac Murmurs, covering all phases of valvular abnormalities. More than 150 pages are devoted to ausculation of various congenital lesions, all graphically demonstrated, indicating the rapidly growing interest in this area of cardiology.

In the chapter on Miscellaneous Auscultation Findings, one will find a variety of situations from endocarditis to myocarditis, all beautifully interpreted for the listener.

In this age, when many of us depend on IBM diagnosis, this book will be a refresher and a source of

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great interest to the student-physician who has an intelligent desire to interpret adequately what his stethoscope brings to him.

The physician who believes in the value of bedside diagnosis, will find his powers of observation and deduction sharply heightened by a careful reading of this book.

* * * *

**CHRISTOPHER'S MINOR SURGERY—By Alton Ochsner, M. D., F. A. C. S., Professor of Clinical Surgery, Tulane University School of Medicine; and Michael E. DeBakey, M. D., F. A. C. S., Professor of Surgery and Chairman of the Department of Surgery, Baylor University College of Medicine. Pp. 539, with numerous illustrations. W. B. Saunders Company: Philadelphia & London. Eighth Edition. 1959. Price $10.50.**

In this edition the authors have revised and reappraised certain chapters extensively. Three completely new chapters, Injuries of the Hand, Diseases of the Breast, and Physical Treatment in Minor Surgery, have been added. The chapter on arterial diseases, arteriosclerosis, is well done and describes some of the more recent methods of diagnosis and treatment of this condition.

This book is intended primarily to serve as a quick reference for the busy practitioner, resident physician and the medical student in the diagnosis and treatment of surgical conditions that do not require hospitalization. Having done general practice and now serving a residency in surgery, I feel that the book serves this purpose well.

The material is well arranged and adequately illustrated. This is one of the best of several similar texts on minor surgery which have been published in the United States in the past five years.—James E. Boggs, M. D.

* * * *

**THE CHEMICAL PREVENTION OF CARDIAC NECROSES—By Hans Selye, M. D., Ph. D., D. Sc., Professor and Director of the Institute of Experimental Medicine and Surgery, University of Montreal, Canada. Pp. 235, with illustrations and tables. The Ronald Press Company, 15 East 26th Street, New York City. 1958. Price $7.50.**

This book opens its preface with the statement, "Cardiac necrosis is the most common cause of death in man," and it is stated that "the object of this monograph will be to coordinate data in the light of newly acquired knowledge about the electrolyte steroid cardiopathies."

There are five chapters and 195 pages. Chapter 1 is preceded by a glossary which the average reader will find highly necessary.

In the large second chapter, pathogens and conditioning factors of cardiac necroses is the real meat of the work and for those with the necessary scientific background, it will contain a great fund of vital information.

There are short chapters on Outlook, Theories, Summary and Conclusion.

The book is precisely annotated with over 400 references and the index is meticulous in detail.

The student versed in physiology and pathology with an incentive to research, will find this book highly informative and a very worthy reference.


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**YOUR HEART: A HANDBOOK FOR LAYMEN—By H. M. Marvin, M. D., Associate Clinical Professor of Medicine, Yale University School of Medicine, and Past President of the American Heart Association. Pp. 335. Doubleday & Company, Inc., 575 Madison Avenue, New York 22, New York. 1960. Price $4.50.**

This book of 335 pages by a well known cardiologist attempts to provide laymen with a short, adequate report on the common problems of heart disease. The book is written in the hope that it might bring clearer understanding of the heart's functions and disorders to non-medical readers.

The first 150 pages, devoted to a description of the heart, blood vessels, irregularities of rhythm and the four principal types of heart disease, namely, Rheumatic Heart Disease, Hypertensive Congestive Heart Failure, Angina and Coronary Occlusion, are concisely explained. The heart disease victim will find sufficient definition of his complaints and disease. It will be a boon to the time-pressed cardiologist to refer his patient to this extra curricular explanation.

The chapters devoted to Coronary Occlusion and the discussion of Coronary Artery Sclerosis are skillfully written in understandable language for the intelligent layman. The prevailing theories are well discussed and the conclusions are not dogmatic.

The chapter on anticoagulants may help the reading patient, or may leave him as confused as many physicians are today regarding the proper use of this extremely important therapy.

The chapter on the effects of tobacco smoking on the heart is an able presentation of the pro and con facts of the argument, but will bring no solution to the layman earnestly seeking a conclusive answer. The author, in spite of seemingly conclusive evidence, takes no stand on this important adjunct to treatment.

The chapters concerned with rehabilitation, electrocardiograms and x-ray studies of the heart are highly informative and will answer many questions for the interested person.

The layman will have a better understanding of heart disease after reading this book and should have a closer rapport with his physician. The function of the book is to explain common heart ailments. It is not a "do it yourself" therapy.

* * * *

**CURRENT THERAPY—1960. Edited by Howard F. Conn, M. D. Consulting Editors: George E. Burch; M. Edward Davis; Vincent J. Derbes; Garfield G. Duncan; Hugh J. Jewett; Clarence S. Livingood; Perrin H. Long; H. Houston Merritt; Walter L. Palmer; Hobart A. Reimann; Ralph Wayne Rundles; and Robert H. Williams. Pp. 808. Philadelphia and London: W. B. Saunders Company. 1960. Price $12.00.**

Current Therapy, an annual volume covering the best in medical therapeutics, is ably edited by Howard F. Conn. The consulting editors show only one change from the previous year.

The arrangement of the book is essentially unchanged. The rotation of topics and authors brings a fresh reading to many subjects, although the content may show little alteration. Some of the new authors are less authoritative than the previous contributors. Viral diseases of the respiratory tract are now of sufficient importance to warrant a separate chapter.

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In the preface the editor mentions specifically new drugs, such as vasomotor stimulants and anticoagulants.

This volume is an excellent index for precise information concerning the latest therapeutic studies and will be used daily by the up-to-date practitioners.

Actually, the information in the 1960 Volume has nothing new that could not be offered in a small supplement to the 1959 Volume.

* * * *

**THE STORY OF DISSECTION—By Jack Kevorkian, M. D. Pp. 80. Philosophical Library, Inc., 15 E. 40th Street, New York City. 1959. Price $3.75.**

This small volume of 80 pages is divided into ten chapters, with a page and a half of references. The chapter headings are: Antiquity; Classical Greece; Hellenistic Alexandria; Rome; Byzantium; Middle Ages; Renaissance; Baroque Period; Nineteenth Century; Twentieth Century.

Likenesses of the following sixteen individuals are reproduced in a very satisfactory manner: Hippocrates, Galen, Vesalius, Fernel, Harvey, Sylvius, Malpighi, Bonet, Morgagni, Van Swieten, Corvisart, Bichat, Cruveilhier, Rokitansky, Muller, and Virchow.

These pictures add a personal touch to the interesting narrative of the progress and lack of progress of dissection through the ages as recorded by the author.

On page 80, there is a linear history of dissection, in graphic form, showing the actual performance of dissection and the attitude toward and availability of dissections by centuries.

As the reviewer read through this book, he was impressed by the manner in which religions and social customs, political pressures, and different philosophies played outstanding roles in the trend toward the meticulous study of the human body. The great impetus which individual thoughts and individual personalities gave to the advancement of understanding, as well as, occasionally, to the retardation of progress, in the field of dissection is well brought out in the book. It is recommended reading for the anatomist, the pathologist, and other members of our Association who enjoy the historical and philosophical background of our profession.—E. Lyle Gage, M. D.

* * * *

**A PRACTICAL GUIDE FOR GENERAL SURGICAL MANAGEMENT—By Julian A. Sterling, M. D., Assistant Professor of Surgery, Graduate School of Medicine, University of Pennsylvania, Philadelphia. Pp. 67. Vantage Press, Inc. 1959. Price $3.00.**

This 62-page book is written specifically for the use of interns and residents assigned to the surgical ward service of a hospital. It is intended to orient each member of the surgical team to his responsibilities in the care of patients with surgical problems. Details regarding genitourinary surgery, maxillofacial surgery, neurosurgery, orthopedic surgery, and thoracic surgery purposely have not been emphasized.

The preoperative and postoperative care of the most major general surgical problems, both in adults and

## OFFICERS OF COMPONENT SOCIETIES

| Society | President | | Secretary | | Meetings |
|---|---|---|---|---|---|
| Barbour-Rondolph-Tucker | Samuel C. Johnson | Porsons | Charles L. Leonord | Elkins | 3rd Thurs. |
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| Brooke | Jomes E. Wise | Follansbee | H. L. Hegner | Wellsburg | |
| Cabell | I. Ewen Taylor | Huntington | W. L. Neal | Huntington | 2nd Thurs. |
| Central West Virginia | John E. Echols | Richwood | Jane Freeman | Buckhannon | As Scheduled |
| Eastern Panhandle | George F. Pugh | Martinsburg | F. A. Hamilton, Jr. | Martinsburg | Quarterly |
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| Greenbrier Valley | E. T. Cobb | Ronceverte | Jomes Hamilton | Morlinton | 2nd Wed. |
| Hancock | George Naymick | Weirton | Arthur Phillips | Weirton | 2nd Tues. |
| Harrison | Richord V. Lynch, Jr. | Clarksburg | Andrew J. Weover | Clorksburg | 1st Thurs. |
| Kanawha | Milton J. Lilly | Chorleston | A. B. Curry Ellison | Charleston | 2nd Tues. |
| Logan | Ray M. Kessel | Logan | Luke Combs | Man | 2nd Wed. |
| Marion | J. Dovid Lindsay, Jr. | Fairmont | G. Thomas Evons | Fairmont | Last Tues. |
| Marshall | H. B. Ashworth | Moundsville | J. W. Myers | Moundsville | Semi-Ann. |
| Mason | C. Leonord Brown | Pt. Pleosant | Don Glassman | Pt. Pleasant | |
| McDowell | Guy E. Irvin | Welch | George L. Fischer | Welch | 2nd Wed. |
| Mercer | W. E. Copenhaver | Bluefield | John J. Mahood | Bluefield | 3rd Mon. |
| Mingo | Fronk J. Burian | Williamson | Russell A. Solton | Williamson | 2nd Thurs. |
| Monongalia | Dovid Z. Morgan | Morgantown | C. A. Logue | Morgontown | 1st Tues. |
| Ohio | L. A. Lyon | Wheeling | Robert W. Leibold | Wheeling | 4th Tues. |
| Parkersburg Academy | Jack J. Stark | Belpre, Ohio | Robert M. Biddle | Parkersburg | 1st Thurs. |
| Potomac Volley | P. R. Wilson | Piedmont | H. L. Eye | Fronklin | 2nd Wed. |
| Preston | John F. Lehmon | Kingwood | C. Y. Moser | Kingwood | 4th Thurs. |
| Raleigh | F. Vivan Lilly | Beckley | Preston C. Davis | Beckley | 3rd Thurs. |
| Summers | Jock D. Woodrum | Hinton | A. W. Holmes | Hinton | 3rd Wed. |
| Taylor | R. D. Stout | Grafton | Herbert N. Shanes | Grafton | Lost Thurs. |
| Wetzel | Lemoyne Coffield | New Martinsville | C. P. Watson, Jr. | New Martinsville | Monthly |
| Wyoming | E. M. Wilkinson | Pineville | R. E. Newman | Mullens | Quarterly |

in children, is very well handled, as is the treatment of peripheral vascular disease, cardiac tamponade, traumatic shock, etc.

The author devotes considerable time to discussion of fluid requirements, both parenteral and oral. In addition, space is devoted to the administrative functions of the house staff, plus planning of clinical case presentations and mortality conferences.

The last three pages of the book are devoted to standard laboratory values, which is a most useful addendum for the intern and resident.

The author has included a wealth of valuable information for house officers on the general surgical service. This should be of great value as a guide to the new surgical house officers.—William F. Hillier, Jr., M. D.

* * * *

## Books Received

**CHRISTOPHER'S TEXTBOOK OF SURGERY.**—Edited by Loyal Davis, M. D., Chairman of the Department of Surgery, Northwestern University Medical School, Chicago, Illinois. Pp. 1551, with 1597 illustrations on 810 figures. Seventh Edition. Philadelphia and London: W. B. Saunders Company. 1960. Price, $17.00.

* * * *

**A TRAVELER'S GUIDE TO GOOD HEALTH**—By Colter Rule, M. D., New York City. Pp. 266. Doubleday and Company, Inc., 575 Madison Avenue, New York 22, N. Y. 1960. Price $3.95.

* * * *

**NEUROSURGERY, VOLUME II** (Most recently published volume in the series of the official History of the Medical Department, United States Army, in World War II)—Prepared and published under the direction of Major General S. B. Hays, the Surgeon General, USA; Editor in Chief, Colonel John Boyd Coates, Jr., (MC); Editors for Neurosurgery, R. Glen Spurling, M. D., and Barnes Woodhall, M. D.; Associate Editor, Elizabeth M. McFetridge, M.A. Pp 705, with 283 illustrations, 12 color plates, and 15 tables. Superintendent of Documents, Washington 25, D. C. 1959. Price $7.00.

## Int. Cong. of Internal Medicine To Meet in Switzerland

The Sixth International Congress of Internal Medicine will be held in Basle, Switzerland, August 24-27, 1960. Papers will be presented by 70 leading internists from over the world, and there will be simultaneous translation of lectures in German, French and English.

A copy of the program and registration form for the Congress may be obtained by writing the Secretary, Sixth International Congress of Internal Medicine, Steinentorstrasse 13, Basle 10, Switzerland.

## WVU School of Medicine Receives Grant

The National Institutes of Health, the Public Health Service research center at Bethesda, Maryland has announced the award of 20 grants, totaling $733,143 to support training of research scientists in basic medical and health-related sciences.

A grant of $9,990 was made to the West Virginia University School of Medicine for a training program in physiology. Dr. David W. Northup, a member of the faculty, will be the program director.

## Film on AMA Clinical Meeting Available for Showings

A 16 mm sound film which reviews the important scientific developments which were presented during the Clinical Meeting of the American Medical Association in Dallas last December is now available for showings before county medical society meetings and hospital staff conferences.

The 30-minute sound film, "Medicine Report," was produced by Fordel Films of New York.

Members of medical and allied groups may obtain the film by writing to either the AMA Film Library, 535 North Dearborn Street, Chicago 10, Illinois, or the Audio-Visual Department, Schering Corporation, Bloomfield, New Jersey.


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## AMA Committee To Study Proposed Medical Scholarship Program

Dr. William F. Norwood of Los Angeles, California, has been appointed staff director of a special study committee appointed by the American Medical Association to initiate immediate action on the establishment of a scholarship program for medical students.

Doctor Norwood, who is chairman of the division of legal and cultural medicine, College of Medical Evangelists, has been a member of the faculty at that school since 1933. From 1950 to 1951 he took a leave of absence to serve as a staff associate in a survey of medical education sponsored by the AMA and the Association of American Medical Colleges.

The AMA House of Delegates adopted a resolution at the Clinical Meeting in December which stated that a scholarship fund should be established to aid deserving students to enter the field of medicine, and that such a fund be backed by the AMA as a primary sponsor.

It acted on the recommendation of the AMA Council on Medical Education and Hospitals which reported it had found sufficient evidence of a real need for a scholarship program.

The 12-member committee will make its initial report to the House of Delegates at the annual meeting of the AMA in Miami Beach in June.

## The Forand Bill

Announcement by HEW Secretary Flemming that the Administration has failed to come up with a suitable alternative to the Forand Bill is significant. Seven months ago (July 1959), Flemming, in the House Committee Hearings, asked for time to explore other means of meeting the old-age sickness and hospitalization problem. Admitting his Department has failed to find a suitable alternative, he concludes the Administration's past opposition may have to be reviewed.

Flemming's announcement is unlikely to have been issued without Administration preview. The Forand Bill represents one of the more controversial and positical issues of the 1960 Presidential race. Importance to be attached to the votes of America's fourteen million oldsters is not underestimated by Republicans or Democrats.

Forand has indicated he is not necessarily wedded to his Bill; that he welcomes any practical modification or alternative. He does insist, however, something constructive be done about the old-age sickness problem and done soon.

In view of possible reversal of the Administration's stand, this reasonably receptive attitude of the Bill's sponsor should not be ignored. There is certainly less danger in exploring constructive modifications of the Bill than in reinforcing an attitude of uncompromising opposition. Medicine, by the latter course may be committing itself to a dangerously inflexible position running counter to public opinion.

Public opinion is getting tired of uncompromising stands on issues of national welfare. The "dog-house" built by the steel strike could unwittingly find private medicine its first occupant.

The nub of catastrophic medical expense is soaring hospital costs. Oldsters, generally, just don't have this kind of money. They do have personal dignity, the vote, and a lot of public concern for their welfare. Since the medical profession can't afford to subsidize hospital costs, maybe the time has come to quit running interference for the hospital-insurance company team. This seems particularly apropos since the hospitals can't decide if they like their teammates and which goal they want to defend.

Instead, it might be just the time to focus a little attention on defining and protecting our own interests. A "Leave us out, thank you" toward surgical fees and other professional inclusions of the Bill and a "Friend of the Court" attitude toward helping modify it to give oldsters and the taxpayers their money's worth—might be just the right prescription. It might, just incidentally, be the golden opportunity to find the answer to rising medical costs and the survival of private practice.
—T. K. Callister, M. D., in Medical Times.

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Vol. 56 No. 5

# The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Assaciatian

Box 1031 Charleston 24, W. Va.

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Huntingtan

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Published monthly by the West Virginia State Medicol Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the outhenticity of opinion or statements made by outhors or in communications submitted to this Journal for publication. The outhor or communicont shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per yeor; 50¢ per single copy. Advertising rates furnished on request. Address oll communications to Business Manager, West Virginia Medicol Journal, Box 1031, Charleston 24, West Virginia. Phone Dlckens 4-4625.

Member 1960

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# WVU Medical Center
# —News—

THREE prominent physicians presented papers recently before the student body and faculty as part of the Medical Center Lecture Series which was instituted during the second semester. Dr. Frank M. Mateer, assistant professor of medicine at the University of Pittsburgh School of Medicine, delivered a paper on March 11 on the subject of "Acute Renal Failure and the Role of the Artificial Kidney."

On March 18, Dr. Francis Jackson, associate professor of surgery at the University of Pittsburgh School of Medicine, presented a paper on "Cancer Chemotherapy as an Adjunct to Surgery." The guest speaker

Francis Jackson, M. D.

Frank M. Mateer, M. D.

on April 1 was Lt. Colonel Joseph Goldstein (MC), who spoke on the subject of "Atomic Weapons Casualties—Their Number and Management."

### Curriculum Announced for Fall Semester

A curriculum for third and fourth year students in the School of Medicine was announced recently by Dean Edward J. Van Liere. The new program, comprising "units of instruction" rather than semesters or terms, becomes effective next fall when the first third-year class is enrolled.

Subject areas, together with total units of instruction in each, will be as follows:

Medicine and medical specialties, 4, (junior year, 2, and senior, 2); Surgery and surgical specialties, 3 (junior, 2, and senior, 1); Obstetrics and Gynecology, 1 (junior year); Pediatrics, 1 (junior year); Psychiatry, 1 (senior year); Radiology, ½ (senior year); Public Health and Preventive Medicine, ½ (senior year); and electives, 1 (senior year).

Dean Van Liere said a minimum of 33 to 36 weeks of actual instructional time will be included in a year's work. During the junior year students will take clinical clerkships in medicine, surgery, obstetrics and gynecology, and pediatrics, in addition to attending lectures, demonstrations and discussions in the fields of health and preventive medicine and psychiatry.

• **Compiled from material furnished by John B. Harley, M. D., Assistant Professor of Pathology and Public Information Officer at the WVU Medical Center in Morgantown, W. Va.**

### Diagnostic and Treatment Services

In the clerkships, each student will be responsible for specific patients from the hospital or out-patient service of the department in which he is serving. Dean Van Liere said each student will be part of a team providing diagnostic and treatment services to the patient under strict supervision of faculty members of the department.

Students will take the patient's history, perform physical examinations, and perform or secure indicated laboratory studies. They will record their findings and present case reports for discussion by members of the faculty. In addition to his clinical work, the student will be required to attend such lectures or other "whole class" exercises scheduled regularly by various departments.

The school will award its first M. D. degree in the spring of 1962.

### Tour of Defense Installations

Dean Edward J. Van Liere and Dr. Daniel T. Watts, professor of pharmacology, participated in the Medical Education for National Defense Orientation Tour from March 17 to March 23. The tour was arranged to familiarize medical school administrators and faculty members with various aspects of the National Defense Program that are pertinent to medical education.

Dean Van Liere and Doctor Watts, along with representatives from 20 other medical schools, visited Navy and Marine activities in San Diego, California and vicinity, March 17-19. The group then traveled to San Antonio, Texas, to observe Army and Air Force installations, March 21-23.

The tour was arranged for representatives from medical schools which have recently affiliated with the Medical Education for National Defense program, and is intended to familiarize those representatives with various aspects of military medicine that can be incorporated into existing medical school curriculum.

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# The Month in Washington

• From the Washington Office of the American Medical Association.

DEFEAT of the Forand Bill in the House Ways and Means Committee highlighted developments on the issue of legislation to provide more Federal health care for the aged. On March 31, the Committee voted 17 to 8 to shelve the Forand Bill which would increase Social Security taxes to provide surgical benefits and limited hospitalization and nursing home care for Social Security beneficiaries, except the disabled; however, the issue remained very much alive.

### Alternative Proposals Considered

The Eisenhower Administration and Congressmen were separately considering various alternative proposals to provide additional health care for the aged, but outside the Social Security system. And the action of the House Committee did not rule out the possibility of Forand-type legislation being brought up in the Senate later this session.

The House Committee vote against the Forand Bill came during the drafting of an omnibus measure of revisions in the Social Security program. The Committee voted tentatively to bring physicians under Social Security.

The Committee also favored elimination of the requirement that a disabled person must be 50 years or older to be eligible for Social Security payments.

### Health Insurance on Voluntary Basis

Arthur S. Flemming, Secretary of Health, Education and Welfare, said the Administration was considering a plan for Federal payments to the states to help aged needy persons buy private health insurance on a voluntary basis. He said he hoped the plan would be ready for submission to Congress by late April.

Sen. Jacob K. Javits (R., N. Y.) and seven other Republican Senators introduced similar legislation in the Senate. The bill called for the Federal government and states jointly to put up about $1 billion a year to help persons 65 years and older, and their spouses, to buy private health insurance. The coverage would include medical care in home and office, diagnostic services, hospitalization and nursing home care.

Another plan being considered by some other members of Congress would broaden the Federal-State public assistance program to provide more health care for needy older persons.

### Administration Opposes Forand Bill

Both President Eisenhower and Vice President Nixon reiterated their opposition to any compulsory health plan such as the Forand Bill. The President told a news conference that such plans would be a definite step toward socialized medicine. He proposed that medical care for the aged be improved through further development of voluntary health insurance programs.

Vice President Nixon stated his position in a letter to physicians who had communicated with him about the matter.

"The Vice President, throughout his career as a public official, has consistently opposed and will continue to oppose any compulsory health insurance program," the letter said. "This, of course, includes the Forand Bill. . . ."

"He believes that the best way to handle the problem of people over 65 who do not have and cannot afford health insurance is through a program which will enable those who desire to do so to purchase health insurance on a voluntary basis."

On the other side, three candidates for the Democratic nomination for President—Sens. John F. Kennedy (Mass.), Hubert H. Humphrey (Minn.) and Stuart Symington (Mo.)—said they would push for passage of Forand-type legislation.

### AFL-CIO Supports Bill

The AFL-CIO continued its all-out campaign in support of the Forand Bill. Leaders of the labor union repeatedly attacked the American Medical Association for opposing the bill.

One of the attacks prompted Dr. Louis M. Orr, AMA President, to protest in a letter to AFL-CIO President George Meany against the union's "deliberate distortions of the truth, perversions of the truth, and outright untruths."

Doctor Orr charged that allegations in a political memorandum of the AFL-CIO's Committee on Political Education (COPE) "not only . . . attempt to impugn the motives and competence of the nation's physicians, but they seek to mislead labor's rank and file, the members of Congress, and the American people as a whole."

"When the AMA opposes any legislative health measure, it does so because its members believe that it would lead to poorer—not better—health care for the people of this country," Doctor Orr said.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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# Obituaries

### WILLIAM ARCHIBALD FLICK, M. D.

Dr. William Archibald Flick, 76, of Keyser, died April 6, 1960, at a hospital in Romney. Death followed injuries sustained in an automobile accident on April 2.

Doctor Flick was born near Harrisonburg, Virginia, December 23, 1883, son of the late Silas and Hattie (Berry) Flick. He received his academic education at Shenandoah College, Dayton, Virginia, graduating with a B.A. degree. He received his M.D. degree from Emory University School of Medicine, Atlanta, Georgia, 1917. He interned at the Lying-In Hospital, New York City, and served residencies at Hines Memorial Hospital, Chicago, and Mt. Sinai Hospital, New York City. He had postgraduate work at the New York Postgraduate Hospital and also at clinics at Johns Hopkins.

He was with the USPHS for two years and for several months was a member of the staff of the VA Hospital in Atlanta, Georgia.

Doctor Flick was an active member of the National Guard for several years, and retired with the rank of Captain. He located in Keyser in 1927, where he continued in active practice until his recent accident. He was an honorary member of the Potomac Valley Medical Society, the West Virginia State Medical Association and the American Medical Association. He had served a term as president of his local medical society.

Besides his widow, the former Rosa Franklin Bailey, he is survived by a brother, Luther Flick of Harrisonburg, Virginia.

* * * *

### WALTER NELSON ROWLEY, M. D.

Dr. Walter N. Rowley, 66, of Huntington, died on March 16, 1960, following a short illness.

Doctor Rowley was born in Rochester, Minnesota, April 10, 1893, son of the late John and Nora Rowley. He received his M.D. degree from Northwestern University Medical School in 1918 and served his internship at Chelsea Naval Hospital. After completing a residency at the Mayo Clinic, he located in Huntington in 1923, where he continued the practice of his specialty of obstetrics and gynecology until his death.

He served in the Navy during World War I and was active in the Naval Reserve until 1942, when he was released with the rank of Lieutenant Commander.

In 1940, he founded the Rowley Clinic in Huntington, which he operated continuously until his death.

He was a member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association, and was a Fellow of the American College of Surgeons.

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Besides his widow, the former Hilda Charlotte Bachini, he is survived by two daughters, Mrs. James Hesson and Mrs. R. F. McVickers, both of Huntington.

* * * *

### SCIOTO P. WALKER, M. D.

Dr. Scioto P. Walker, 82, of Huntington, died at his home in that city on March 26, 1960, following a long illness.

Doctor Walker, a native of Wyoming County, received his M.D. degree from Maryland Medical College in 1911, and located at Oceana, in his home county, where he engaged in general practice until 1918, when he moved to Huntington, where he continued in general practice until he became seriously ill a few months ago.

He was a member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

He is survived by a son, Robert P. Walker, who resides at 1019 Jackson Avenue, Huntington.

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Every doctor must become familiar with the medical aspects of nuclear radiation. He must learn more about alpha, beta and gamma rays than he ever learned in medical school. He must have some basic knowledge of bomb fallout and how the bomb causes blast damage, burns and hemorrhage. It is essential that he know how much radiation a person can take every day and how much is lethal. The field of radiation is now a most important medical problem.—Jack R. Karel, M.D., in Journal, Medical Society of New Jersey.

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### Modern Psychiatric Revelation

With the enlightenment of the public and the medical profession, psychiatry once again is an accepted son of medicine and the mental hospital is regaining its just status. With the reversal of the trend of the last 150 years, as yet incomplete, it is not impossible to dream that the complete abolition of the human warehouses is in sight, and the mentally ill will require and ask for no more than equal facilities at home that in most instances already are provided for other illnesses.—E. Ivan Bruce, Jr., in Texas State Journal of Medicine.

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# County Societies

### BARBOUR-RANDOLPH-TUCKER

Dr. D. Franklin Milam of Charleston was the guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker Medical Society which was held at the Coach N' Four Restaurant in Elkins on March 17. He presented an interesting paper on "Tumors of the Urinary Tract."

During the business meeting, the following physicians were elected to membership in the Society: Bill R. Blackburn, John H. Glenn, Hossein Golji and R. A. Richeson.

Several members discussed the Forand Bill which is now pending in Congress.—Charles L. Leonard, M. D., Secretary.

* * * *

### CABELL

At the regular monthly meeting of the Cabell County Medical Society, held in the Georgian Terrace of the Hotel Frederick in Huntington, March 10, 1960, the following eulogy to the memory of the late William B. MacCracken, M. D., was read by Dr. Francis A. Scott:

**William Benjamin MacCracken**

William Benjamin MacCracken was born September 2, 1908, at Mt. Vernon, New York. His early education was received in the public schools of New York and New Jersey. He attended Columbia University, studying in the College of Engineering for one year, then transferring to the Pre-Medical Course in his second year at that University. He graduated from The College of Physicians and Surgeons of Columbia University in 1932.

He interned for two years at Bellevue Hospital, New York City, then spent five years as a Fellow at New York Orthopaedic Hospital, completing his training in 1938.

Dr. MacCracken—"Bill" or "Mac," as his friends called him—went on active duty with the Medical Corps of the United States Navy in June, 1941, being attached to the famous "Carlson's Raiders" of the United States Marines. He saw active service in the South Pacific area, and was awarded the Navy Cross and the Presidential Citation for his admirable service with the United States Marines.

I first met "Bill" in New Caledonia in March, 1943, where he was recuperating from malaria and dysentery acquired at Guadalcanal, Solomon Islands. I was later stationed with him at the United States Navy Hospital, Brooklyn, New York. On our discharge from active duty I invited him to become my associate in the practice of Orthopedic Surgery in Huntington, West Virginia, and he accepted. We were thus associated from February 1, 1946, until his untimely death on February 29, 1960.

William MacCracken was a man's man, an individual of absolute integrity, terrific physical stamina, and with a keen dry sense of humor. He was a perfectionist in his life's work, Orthopedic Surgery, as well as in his hobbies of gun collecting, carpentry, and literature. The excellent results of his orthopedic skill will be remembered in this com-


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munity by this present generation, but his contributions to medical literature will be read and appreciated for many generations.

By his death we, who knew him, have lost a valued friend and the community, a valuable practitioner of the art of Orthopedic Surgery.

It was announced by Dr. M. L. White, Jr., that the parents of twelve-year-old Kenneth Jenks of Huntington, who died two months ago of staphylococcus pneumonia, desire to contribute about $3,000 toward the creation of a Memorial Medical Scholarship Fund for graduates of high schools in Cabell county.

Doctor White moved "That the Society endorse the Fund, help to administer it, endeavor to perpetuate it and thank the Jenks for their altruism." The motion was seconded by Drs. Scott, Walter E. Vest and A. C. Esposito and passed.—W. L. Neal, M. D., Secretary.

* * * *

**HANCOCK**

Members of the Hancock County Bar and the Medical Society held a joint meeting at the Weirton General Hospital on April 7.

The guest speaker was Judge Frank C. Haymond of the West Virginia Supreme Court of Appeals. He was introduced by Judge J. Harold Brennan of the first Judicial District.

Judge Haymond discussed the Interprofessional Code adopted between physicians and attorneys on the national level. He is chairman of the American Bar Association's Interprofessional Code Committee.

Brief addresses of welcome were delivered by William Conklin, president of the Hancock County Bar Association, and Dr. George Naymick, president of the Medical Society.—Arthur S. Phillips, M. D., Secretary.

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**McDOWELL**

Dr. Freeman L. Johnston of Welch was the guest speaker before the regular monthly meeting of the McDowell County Medical Society, held at Grace Hospital in Welch on March 16, 1960. He discussed the subject of acute abdominal pain and presented several cases concerning non-surgical causes of such pain. The cases were discussed by several of the members.

The President, Dr. Guy E. Irvin, presided at the meeting, which was attended by 18 members and guests.—George L. Fischer, M. D., Secretary.

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**MERCER**

The regular monthly meeting of the Mercer County Medical Society was held at the University Club, West Virginian Hotel, in Bluefield, on March 21, 1960.

Dr. David F. Bell, Jr., reviewed "Recent Advances in Laboratory Tests Useful in Medical Diagnoses." He also discussed new serological tests and said that transaminase determinations are helpful in the diagnosis of liver disease as well as in cardiovascular disease.

At the business meeting which followed the scientific program, Dr. P. R. Fox was elected to honorary membership in the Society.

Dr. W. E. Copenhaver, the president, presided at the meeting which was attended by 38 members and four guests.—John J. Mahood, M. D., Secretary.

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*Recording Secretary:* Mrs. Rupert W. Powell, Fairmont
*Corresponding Secretary:* Mrs. James W. Hamilton, Marlinton
*Parliamentarian:* Mrs. J. Preston Lilly, Charleston

### HARRISON

Mrs. Herman Fischer was elected president of the Woman's Auxiliary to the Harrison County Medical Society at a meeting held at the Stonewall Jackson Hotel in Clarksburg on April 7.

Other new officers for the coming year are as follows: Mrs. Bernard W. Wilkinson, president elect, Mrs. Charles S. Harrison, vice president, and Mrs. John D. H. Wilson, treasurer.

Mrs. James A. Thompson, the president, presided at the meeting, and Mrs. Vernon L. Dyer of Petersburg, first vice president of the Woman's Auxiliary to the West Virginia State Medical Association, was an honor guest.

Mrs. L. Dale Simmons, legislative chairman, presented a movie, "The Medicine Man," an educational film designed to combat false claims and food faddism.

Hostesses for the dinner meeting were Mesdames R. T. Humphries, Donald H. Lough, Lynwood D. Zinn and E. Ross Allen.—Mrs. Paul E. Gordon, Correspondent.

* * * *

### MINGO

An outstanding event of the spring season for members of the Woman's Auxiliary to the Mingo County Medical Society was the annual Doctors' Day dinner on Friday evening, March 8, at the home of Dr. and Mrs. W. W. Scott in Williamson. Mrs. Scott, President of the Auxiliary, welcomed the guests and the wife of each physician presented him with a red carnation.

A buffet dinner was served for the 24 Auxiliary members and their husbands, after which special recognition was given Dr. Henry C. Hays and Dr. W. J. Smith for more than 50 years' medical service in the Mingo area. Each was presented with an engraved silver plaque.—Mrs. Robert J. Tchou, Correspondent.

* * * *

### MONONGALIA

The regular monthly dinner meeting of the Woman's Auxiliary to the Monongalia County Medical Society at the Morgantown Golf and Country Club on April 5 was observed as "Guest Night" and each member was invited to bring a friend.

Dinner was served at small tables on the sun porch and spring flowers were used to decorate the tables and the mantles.

At the conclusion of the meal, an interesting program on Medical Hypnosis was conducted by Dr. Eli Abramson of Uniontown, Pennsylvania.

The speaker discussed the early history of hypnosis, the application of it in modern medicine, and his belief in the increasing use of it in the future. With his nurse, Miss Ventura, as a subject, he gave a fascinating demonstration of hypnotic trances. A question and answer period followed the demonstration.

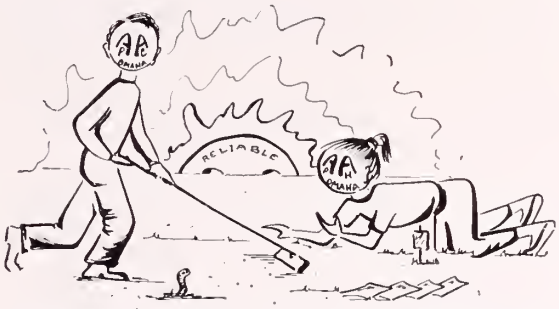
Hostesses for the affair were Mrs. Robert J. Nottingham, chairman, and Mesdames C. B. Pride, George W. Phillips, Hubert T. Marshall and Ralph W. Ryan.—Mrs. Hubert T. Marshall, Correspondent.

* * * *

### OHIO

The Woman's Auxiliary to the Ohio County Medical Society observed its annual "Doctors' Day" with a dinner dance at the Wheeling Country Club. The dance followed a smorgasbord which was served at 7 P. M. Rick Reed and his orchestra furnished music for both the dinner and dance.

Mrs. Robert U. Drinkard was chairman of the committee on arrangements and Mrs. Howard G. Weiler, co-chairman.—Mrs. Robert S. Robbins, Correspondent.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### PARKERSBURG ACADEMY

The annual "Doctors' Day" observance, sponsored by the Woman's Auxiliary to the Parkersburg Academy of Medicine, was held at the Worthington Golf Club on April 7. A chuckwagon buffet was served and table decorations followed a western theme.

Chet Haddox of Pt. Pleasant entertained the group with piano selections and additional entertainment in the way of folk songs were sung by interns from St. Joseph's and Camden-Clark Memorial hospitals.

Arrangements for the observance were under the direction of Mesdames Oliver H. Brundage and Fay Perry Greene, Jr.—Mrs. Donald R. Lantz, Correspondent.

### His Father's Dearest Wish

The West African candidate was faultlessly dressed, fluent, and well-mannered. He responded to our routine questions with deceptive ease and I was not surprised at his smooth handling of the unanswerable chestnut "Why do you want to become a doctor?" "It is, sir, my father's dearest wish."

But some chairmen are never content and ours probed a little further. "Well, sir, he feels I could be an enormous help to him over the things he is not at present allowed to do in his practice. You know, injections, anaesthetics, dangerous drugs, and things like that." "What does your father do then?" "He's a witch doctor, sir."—The Lancet.

### The Physician-Patient Relation

If family ties of blood or marriage are excluded, there is perhaps no relation at once so intimate and yet so dispassionately objective as that between physician and patient. The good doctor is genuinely interested in his patient as a person; yet he cannot permit his professional judgment to be distorted by emotion.

Few physicians dare to trust their judgment in the care of their own families because they know that they cannot be sufficiently objective. Neither can they treat a patient purely as a "case." They must know and care about him as a fellow human being. It is a difficult dual role, which no doctor perfectly fulfills; yet each must strive as best he can to meet this exacting requirement.

In the simplest hypodermic or intravenous injection, an error may cost the patient's life. A single misdirected move in a surgical operation may irretrievably injure an essential nerve or artery. There may be hazards other than those with which the doctor is directly or immediately concerned, as in a patient with an acutely infected gall bladder who also has serious heart disease and diabetes.

The doctor must accept each situation, no matter how severe the handicaps may be, and he must do his best. With clearheaded optimism and confidence he must absorb the weaknesses, the misfortunes, the fears, the suspicions and often the general unreasonableness of the patients.—C. Marshall Lee, Jr., M. D., in The New England Journal of Medicine.


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# Book Reviews

**A TRAVELER'S GUIDE TO GOOD HEALTH—By Colter Rule, M. D., New York City. Pp. 266. Doubleday and Company, Inc., 575 Madison Avenue, New York 22, N. Y. 1960. Price $3.95.**

The author has condensed into two hundred sixty pages a concise but ample description of accident and disease apt to be encountered by a foreign traveler, together with competent medical advice as to the required immunizations, the composition of a simple but ample traveling medical kit, and climaxed by a four-language glossary of words and expressions useful in obtaining adequate medical care in many foreign lands. It should make interesting and informative reading for any foreign traveler. The information contained in any one paragraph might well change a serious threat into a simple problem.—James S. Klumpp, M. D.

* * * *

**BABIES BY CHOICE OR BY CHANCE—By Alan F. Guttmacher, M. D., Obstetrician and Gynecologist-in-chief, Mt. Sinai Hospital, New York City; and Clinical Professor of Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons, New York City. Pp. 289. Doubleday & Company, Inc., 575 Madison Avenue, New York 22, N. Y. 1959. Price $3.95.**

If a book adequately met a crucial and claimant need, Alan Guttmacher's, "Babies by Choice or by Chance" is that book. This is a temperate, wise and sensitive analysis from a medical viewpoint of the world's most neglected social problem brought to the front by a fearless champion of humble and uninformed people.

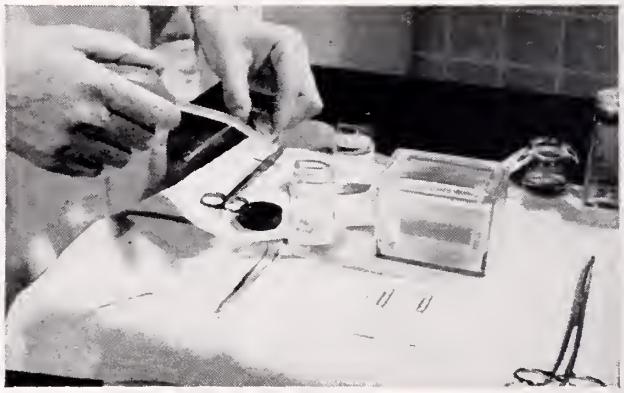
Doctor Guttmacher's life parallels the progressive development of our knowledge of fertility and sterility and it is through his research that we have advanced knowledge in this field. We get excellent results in cases considered hopeless two decades ago.

The book is written in understandable medical-lay language and it presents such an appeal that it well might earn a place on the best seller list. Each problem of fertility and sterility is discussed under chapters on contraception, sterilization, abortion, infertility, and artificial insemination.

Contraception occupies the greater portion of the book and is discussed under the following headings: indications for; methods of use; the "ideal" contraceptive; the history of contraception; and the medical, religious, and legal attitudes toward this timely subject.

As an authority on contraception, Doctor Guttmacher gives a short, concise outline of each indication for the use of birth control. The different methods of contraception are explained in minute detail and he rates the efficiency of each method. The diaphragm-jelly technique rates four plus, the highest, and each method is rated against this standard.

In discussing the search for a better contraceptive device, the author explains how the "pill" prevents ovulation, this being the method recently condemned



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by the Roman Catholic Church. He does not recommend this method as completely fool-proof but lists the criterion for an "ideal" contraceptive and explains what is lacking in each of our present day methods. The classical description of the history of contraception makes interesting background material in understanding our present day medical, religious and legal attitudes toward the subject.

The New York Hospital Story explains how the Roman Catholic Church opposed the establishment of contraception clinics in city hospitals and how Doctor Guttmacher and his committee successfully surmounted the tremendous opposition put up by the Church. The attitude of the Roman Catholic Church is summed up in the statement that "The Church proclaims this prohibition as a law of God, which binds all human beings whether they be members of the Catholic Church or not." This prohibition apparently was not heeded because 55.6 per cent of 2046 patients attending the free contraception clinic at Mt. Sinai Hospital were Catholic, 36 per cent Protestant, 5.2 per cent Jewish, and 3.2 per cent of no faith.

Sterilization is thoroughly discussed, giving all indications for and the methods employed in carrying out these procedures. Several surgical methods are explained and the author presents several tragic case studies where this method of birth control was forbidden, resulting in premature and needless maternal deaths.

Abortion is placed in its proper perspective and is discussed as "The Problem," and "The Doctor's Dilemma": Legal Abortion in the United States. Criminal abortion is also discussed in the light of tragic deaths which occur when this method is resorted to when the patient is denied a hospital supervised therapeutic abortion, because of religious objection.

"Fertility Studies" includes the causes of spontaneous abortion and explains the suturing of the incompetent cervix by the Shirodkar method. The author estimates that 600,000 Childless American couples are a permanent part of our population and the amount of treatment required is a staggering one. Doctor Guttmacher feels that our present day methods offer the infertile couple a 35 to 50 per cent rate of successful treatment over the 20 per cent rate of a decade ago.

Artificial insemination is presented under "History, Indications for and Methods Employed." The legal


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status of offspring resulting from this method is still not clear.

One is impressed with the serious purpose of the author's mission. The basic theme of "responsible parenthood" rings out in each chapter. Doctor Guttmacher speaks out clearly that any couple, regardless of race, creed or economic status is entitled to information on all these discussed problems if they want it. But he also feels that any method employed should be medically indicated, legally defensible, and morally acceptable to the couple and to the physician who prescribes it.—Frederick H. Dobbs, M. D.

* * * *

**CURRENT MEDICAL REFERENCES—Edited by Paul J. Sanazaro, M. D., Associate Professor of Medicine, University of California School of Medicine, San Francisco. Pp. 535. Lange Medical Publications, Los Altos, California. 1959. Price $3.50.**

The Lange Medical Publications have been filling a much needed place in the publication of handbooks for the past two decades. Their latest addition is a completely unique work that I hope will be appreciated by the profession so that it may continue for many years.

Current Medical References is a workable bibliographical listing of about 1000 topics. This is designed as a "starting point" for the investigation of the literature on any of the subjects included. The references selected include both the "classic articles" on the subject and present articles, especially those which offer a complete list of references for further research.

There is no pretense made that this will replace the Current List or the Index Medicus, but the ease with which several references may be obtained will save much time. Since the work covers a period of 20 years, this can be quite a saving of time. This book should become the librarian's right hand. Except when one is compiling a complete bibliography for publication, I would imagine that this work could be used to provide adequate references.

In the present edition, the editor, Doctor Sanazaro, has written nine of the eighteen chapters. This is obviously too broad a field for one man to be acquainted intimately with the literature. As the obvious worth of the handbook is appreciated I would certainly imagine that there will be a great deal more collaboration. In the preface, Doctors Lange and Sanazaro recognize this and request the reader to participate by making corrections, additions and offering suggestions.

This handbook will be a valuable addition to any library regardless of size.—John B. Harley, M. D.

* * * *

**CHRISTOPHER'S TEXTBOOK OF SURGERY—Edited by Loyal Davis, M. D., Chairman of the Department of Surgery, Northwestern University Medical School, Chicago, Illinois. Pp. 1551, with 1597 illustrations on 810 figures. Seventh Edition. Philadelphia and London: W. B. Saunders Company. 1960. Price $17.00.**

Christopher's Textbook of Surgery has been one of the standard books on surgery for the student and the practitioner since 1936. This revision is by Loyal Davis, Chairman of the Department of Surgery, Northwestern University Medical School, and Editor of *Surgery, Gynecology* and *Obstetrics*.

Contributions to this edition are from 82 outstanding surgeons of this country and Canada. Each one has written a section which deals with his own particular interest and about a field in which he is considered an authority. Even with the large number of contributors, the editor has succeeded in keeping the presentations uniform in outline and literary style.

The book deals with all phases of general surgery and in a limited way with the special fields of surgery. There are chapters on pre- and post-operative care, physiology of wound healing, bacteriology as applied to surgery, surgical techniques, fluid and electrolyte balance, and anesthesia, as well as general discussions of diseases which may be treated by surgical means, etc.

The chapters on specific diseases are grouped in regions. Each discussion starts with a general description of the diseases which may be found, followed by anatomy, physiology, pathology and treatment. Where necessary, special considerations are interspersed between these general headings. Chapters on "The Qualifications of a Surgeon" and "Surgical Judgment" are special features of the book.

This book is well illustrated with photographs and line drawings which are adequate and clear. It is primarily a textbook for medical students, but it will be found useful for residents in general practice, generalists, and for surgeons or other specialists as a reference book from which they can readily obtain information about surgical practice which is out of their particular fields.—Hu C. Myers, M. D.

## Books Received

**MEDICAL CARE OF THE ADOLESCENT**—By J. Roswell Gallagher, M. D., Chief, Adolescent Unit, The Children's Hospital Medical Center, Boston, and Lecturer on Pediatrics, Harvard Medical School. Pp. 369, with several illustrations. Appleton-Century-Crofts, Inc., 35 West 32nd Street, New York 1, N. Y. 1960. Price $10.00.

* * * *

**ANATOMY—A REGIONAL STUDY OF HUMAN STRUCTURE**—By Ernest Gardner, M. D., Wayne State University; Donald J. Gray, Ph. D., Stanford University; and Ronan O'Rahilly, M. Sc., M. D., Wayne State University. Pp. 999, with numerous illustrations. Philadelphia and London: W. B. Saunders Company. 1960. Price $15.00.

* * * *

**COMMUNICABLE AND INFECTIOUS DISEASES** — By Franklin H. Top, M. D., Professor and Head, Department of Hygiene and Preventive Medicine, State University of Iowa, Iowa City. Pp. 812, with illustrations. Fourth Edition. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Mo. 1960. Price $20.00.

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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378 (Nov.) 1956. 2. Boger, W. P.: In: Antibiotic Annual 1958-1959, Medical Encyclopedia, Inc., New York. 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959.

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

# Correspondence

THE WEST VIRGINIA ASSOCIATION
FOR MENTAL HEALTH
226½ Capitol Street
Charleston 1, West Virginia

April 5, 1960

Mr. Charles Lively, Executive Secretary
West Virginia State Medical Association
Charleston, West Virginia

Dear Mr. Lively:

In accordance with our recent telephone conversation, I am sending you this material for the contributor's column of the West Virginia Medical Journal. I will appreciate your setting it up under the proper form of address.

Packets of study and discussion materials have been assembled in the office of the West Virginia Association for Mental Health in an effort to help those who are interested in the problems of mental health and mental illness in West Virginia to increase their understanding of needs and possible ways of meeting the needs.

It is our hope that there are mental health committees of county medical societies that would be interested in meeting a few times to study the material and to endeavor to apply any conclusions reached to the problems in this state.

There are a few fundamental ideas to be kept in mind:

1. More knowledge about human development and about mental health and mental illness is available than is being used.
2. Where the findings of research and newer methods are being used, results are more encouraging than before.
3. No one group, tax supported or voluntary, can do this job alone; but cooperation between official agencies and citizens is productive.
4. The ultimate responsibility to know what a good program is and to find ways to achieve it rests with the individual citizen and depends on his or her willingness to take action with others.

Our present hospitals, with all their drawbacks, show we have come a long way since the time that the mentally ill were kept in unheated rooms in jails. Nevertheless, to many, care of the mentally ill means simply adequate food and lodging for the patients, coupled with kindness and an effort to bring them some recreation.

It must be realized that, just as in the medical and surgical fields, there are many different conditions to be dealt with, of many degrees of severity, the same is true in the field of mental illness. Early case findings and treatment are essential. Therefore, the facilities provided by the community should represent a free-flowing continuum of treatment, offering what is necessary for those who are in the early stages of illness, those who are seriously ill, and those who are recovering and need help to get back into normal living.

When the committee has studied this material, attention should be turned to West Virginia. Up-to-date statistics are not available at this point but will be sent to study groups when they have been received from hospitals and clinics and the Department of Mental Health.

These packets may be obtained by writing to the West Virginia Association for Mental Health, 226½ Capitol Street, Charleston, West Virginia. Please enclose $1.00 for handling charges.

The West Virginia Association for Mental Health is the only organization devoted entirely to the promotion of mental health and efforts to protect the interests of the mentally ill. We will welcome any cooperation that the West Virginia State Medical Association feels that it can give.

Very Sincerely yours,

(Signed) Margaret T. Ross, M. D.
Executive Secretary

MTR:lm

## Growing With The Years

The common lot of many older individuals is not a happy one. Numerous problems beset them. Among these there may be illness of one kind or another, domiciliary concern, financial pressure and family tension.

The enlarging number of older citizens which has reached, one might say epidemic proportions, is forcing various organizations, official and voluntary, to search for ways and means to alter, for the better if possible, the overall status of the senior group of our national population.

As a physician, our principal field of interest has focused on the physiologic alterations of performance on the part of oldsters. At the same time we have been searching for a better understanding of the transformations, tissue-wise, appearing in the bones, muscles, the vascular walls and nerve cells with passing time.

There is an abundant literature dealing with these changes; much of it is stimulating. While differences of opinion abound, evidence nevertheless indicates the capacity of these various tissues for self-repair and regeneration if given a reasonable opportunity.

In the improved knowledge of nutrition and a growing awareness of the fundamental importance of exercise to keep tissues and organ systems in a happy functional running order there is the promise of additional life expectancy. The quantitative line is secondary in importance to the preservation of energy within the tisues and body as a whole. This makes for a more healthy, biologic organism which can be maintained in good running order far beyond the previous predicted limits.—Edward L. Bortz, M. D., in Southern Medical Journal.

I forget who it was who recommended men for their soul's good to do each day two things they disliked. It is a precept that I have followed scrupulously, for every day I have got up and gone to bed.—Somerset Maugham.

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| dition | Dosage (daily, in divided doses) | Duration of Therapy |
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| :tious Diarrheas illary and pecific) | *Adults:* 35 to 50 mg/Kg; up to 100 mg/Kg in severe cases. | Up to 7 days |
| | *Children:* 50 mg/Kg; up to 100 mg/Kg in severe cases. | Up to 7 days |
| ›tinal Amebiasis te, subacute, nic) | *Adults:* 0.75 to 1.5 Gm.; larger doses when required. | 5 days |
| | *Children:* 22 mg/Kg; larger doses when required. | 5 days |
| ›perative ›ression of stinal Flora | *Adults:* 2 Gm. | 4 days |
| atic Coma | *Adults:* up to 6 Gm., depending on degree of hepatic insufficiency and response of patient. | See literature |

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**REFERENCES:** (1) Coffey, G. L., *et al.*: *Antibiotics & Chemother.* 9:730, 1959. (2) Personal Communications to the Department of Clinical Investigation, Parke, Davis & Company, 1959. (3) Godenne, G. D.: Paromomycin in diarrheas of infants and children, Antibiotics Annual 1959-1960, New York, Medical Encyclopedia Inc., in press. (4) McMath, W. F. T., & Hussain, K. K.: *Pub. Health* 73:328, 1959. (5) Courtney, K. O., & Thompson, P. E.: Paromomycin as a therapeutic substance for intestinal amebiasis and bacterial enteritis, Antibiotics Annual 1959-1960, New York, Medical Encyclopedia Inc., in press. (6) Shafei, A. Z.: *Antibiotic Med. & Clin. Therapy* 6:275, 1959. (7) Elias, F. L., & Oliver-Gonzales, J.: *Antibiotic Med. & Clin. Therapy* 6:584, 1959. (8) Carter, C. H.: *Antibiotic Med. & Clin. Therapy* 6:586, 1959. (9) Fast, B. B., *et al.*: *Arch. Int. Med.* 101:467, 1958. (10) Mackie, J. E., *et al.*: *New England J. Med.* 259:1151, 1958. (11) Stormont, J. M., *et al.*: *New England J. Med.* 259:1145, 1958.

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JUNE
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Vol. 56 No. 6

# The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone Dickens 4-4625.

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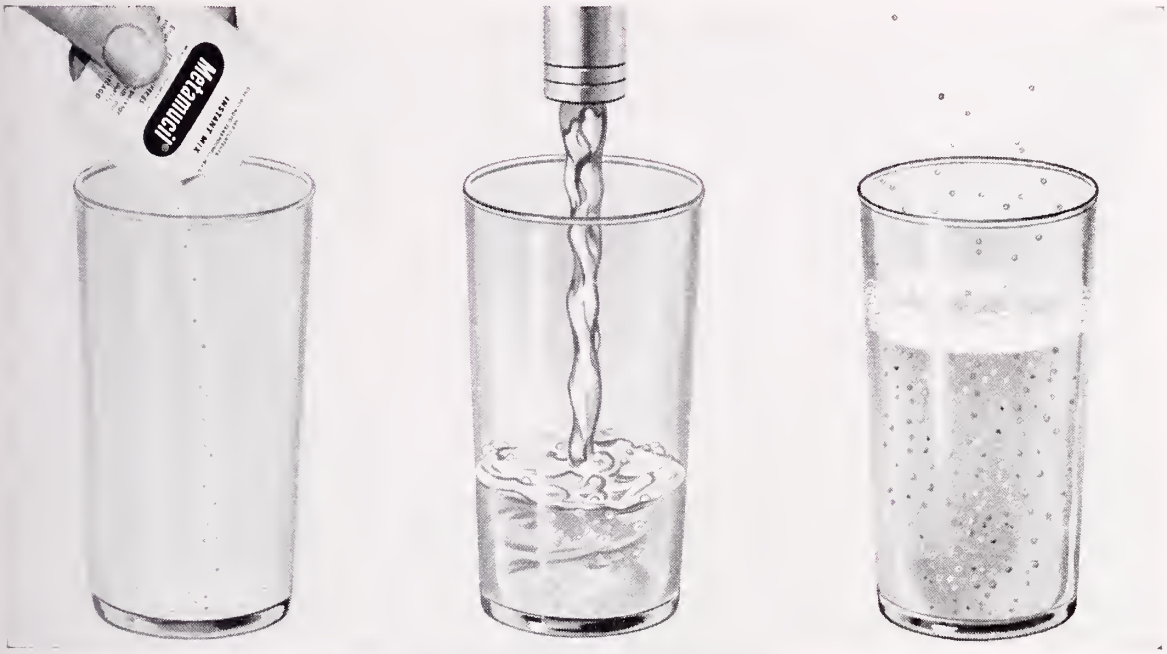


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# WVU Medical Center
# —News—

FORTY-SIX students have been accepted for admission to the entering class at the West Virginia University School of Medicine in September, 1960. The announcement was made recently by Dr. Edward J. Van Liere, Dean of the School of Medicine, and Dr. Clark K. Sleeth, Assistant Dean and chairman of the committee on admissions and scholarships.

The class will consist of 44 men and two women, all of whom are citizens of West Virginia. Nineteen of the students received their pre-medical training at West Virginia University. They are as follows:

**Nineteen Accepted from WVU**

Tommy Joe Altizer, Mallory; David M. Bear, Fairmont; Thomas O. Dotson, Summersville; Louis A. Fabian, Monongah; John D. Harrah, White Surphur Springs; James M. Heaster, South Charleston; David R. Hobbs, Roger E. King and Paul H. Price, Morgantown; and Donald G. Klinestiver, Keyser.

**Visitors from the University of British Columbia in Vancouver, Canada, are shown during a recent inspection trip to the WVU Medical Center at which time they studied the building program and facilities. Left to right, Mr. Donald Cox, Deputy Minister of Hospital Insurance, Dr. Robert Kerr, Professor of Medicine, Dean Edward J. Van Liere, and Dr. John F. McCreary, Dean of the Canadian Institution.**

Other WVU students are Lewis M. Judy, Romney; John A. Karnoupakis and Antonio S. Licata, Weirton; Ruby E. Lemley, Fairview; Benjamin L. Plybon, Iaeger; Donna Marie Robertson, Beckley; Donald E. Southern, Williamson; Larry Jack Stemple, Philippi; and Charles V. Stewart, Jr., Mullens.

**Students Accepted from Other Schools**

Six students received their undergraduate training at Marshall College. They are George R. Baise, H. Andrew Cserny and Richard H. Garretson, Huntington; Abraham Nazem, Williamson; Raymond L. Brown, Jr., Welch; and James A. Lilly, Glenwood.

The following three students received their training at Wheeling College: Thomas L. Ritz, Wheeling, Edward J. Shahady, Fairmont; and Michael B. Curry, Logan.

There were also three students accepted from West Virginia Wesleyan College: William J. Echols, Richwood; Ira F. Hartman II, Buckhannon and James E. Wilkerson, Whitesville.

The remaining students and the schools at which they did their pre-medical work are Walter S. Bowie, Morgantown, Potomac State College; Thomas E. Carter, Bluefield, West Virginia State College; William J. Hanshaw, Dunbar, Morris Harvey College; Joseph J. Renn, III, Martinsburg, Shepherd College; Charles F. Lucas and John N. Ralston, Beckley, Hampton-Sydney College; Harry G. Buchanan, Gilbert, Berea College; Joseph A. Barta, Anawalt, Virginia Polytechnic Institute; John N. Chokatos, Clarksburg, Miami (Ohio) University; Robert M. Jason, Bluefield, University of Texas; Karl Von Metz, Morgantown, University of Virginia; Thomas E. Richardson, Lewisburg, Marietta College; Ernest G. Sayfie, Charleston, University of Cincinnati; Paul V. Watson, Charleston, Wake Forest College; and Thomas E. Weier, Bluefield, University of Michigan.

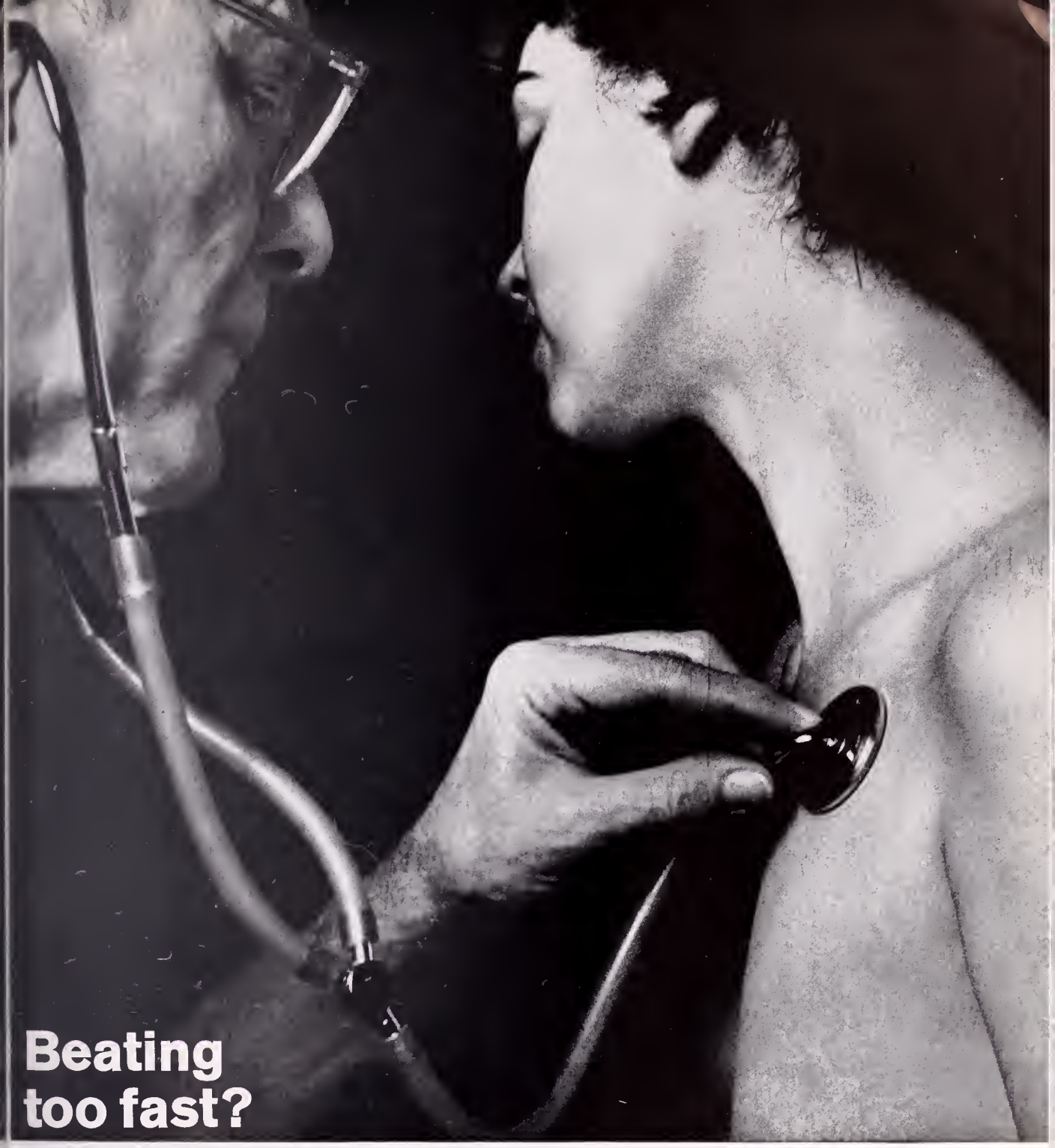
**Medical Center Lecture Series**

President Elvis J. Stahr, Jr., and Mr. Charles Lively of Charleston, executive secretary of the West Virginia State Medical Association, were the guest speakers before the student body and faculty at the Medical Center on April 29.

President Stahr explained the workings of the State Legislature as seen by the University Administration, and Mr. Lively discussed the manner in which the medical, dental, pharmaceutical and nursing professions are affected by legislation on the state level.

The speaker on May 9 was Dr. Myron Aisenberg, Dean of the School of Dentistry at the University of Maryland. His subject was "Malignancies In and About the Oral Cavity."

**• Compiled from material furnished by John B. Harley, M. D., Assistant Professor of Pathology and Public Information Officer at the WVU Medical Center in Morgantown, W. Va.**





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# The Month in Washington

• From the Washington Office of the American Medical Association.

POLITICS now overshadows all other factors in the issue of health care for the aged. It appears certain to be a major issue in this year's campaigning for the White House and Congress, regardless of what Congress does in the field before adjourning this summer.

Both the Democrats and the Republicans are supporting costly, sweeping plans which differ on the basic approach. The major Democratic plans call for use of the Social Security System. The Republican proposals would have the Federal government and the states put up hundreds of millions of dollars to help the aged buy health insurance on a voluntary basis.

### Opposition to 'Political Solutions'

The medical profession and allied groups oppose these political solutions because, among many other important reasons, they actually would not meet the problems of many aged who need help in financing the cost of illness.

Meanwhile, a key Democrat—Rep. Burr Harrison of Virginia—warned Congress against acting on such legislation in this year of a national election. He predicted that if any such legislation should be approved this year, it "would be certain to be a monstrosity."

Noting that various solutions had been proposed, Harrison said:

"The only features which these proposals have in common are that they are all tremendously expensive; they all propose revolutionary change, and they are all complicated, uncertainly-based and little-understood by the prospective beneficiaries."

Harrison, who is a member of the House Ways and Means Committee which handles such legislation, urged that Congress defer action until next year. He recommended that, in the meantime, the Ways and Means Committee "conduct an exhaustive study of the various proposals."

### Administration Bill

In early May, the Eisenhower Administration unveiled a Federal-state, $1.2 billion-a-year plan to help the aged with limited incomes buy broad medical and hospital insurance coverage. Under the plan, an aged person—if able financially—would bear part of the cost of both the insurance and of the medical care and hospitalization.

The Administration's plan immediately ran into widespread opposition. Dr. Louis M. Orr of Orlando, Florida, President of the American Medical Association, said it was based "on the false premise that almost all persons over 65 need health care and cannot afford it."

"This is not a fact," Doctor Orr said. "The truth is that a majority of our older people are capable of continuing a happy, healthy, and, in many cases, productive life. Of the more than 15 million persons in the nation over 65 year of age, only 15 per cent are on old-age assistance."

Doctor Orr said neither the Administration's proposal nor the Forand-type Social Security approach is tailored to meet the problems of the undetermined number of older persons who, "although able to finance other costs, find it difficult to withstand the additional burden of the cost of illness."

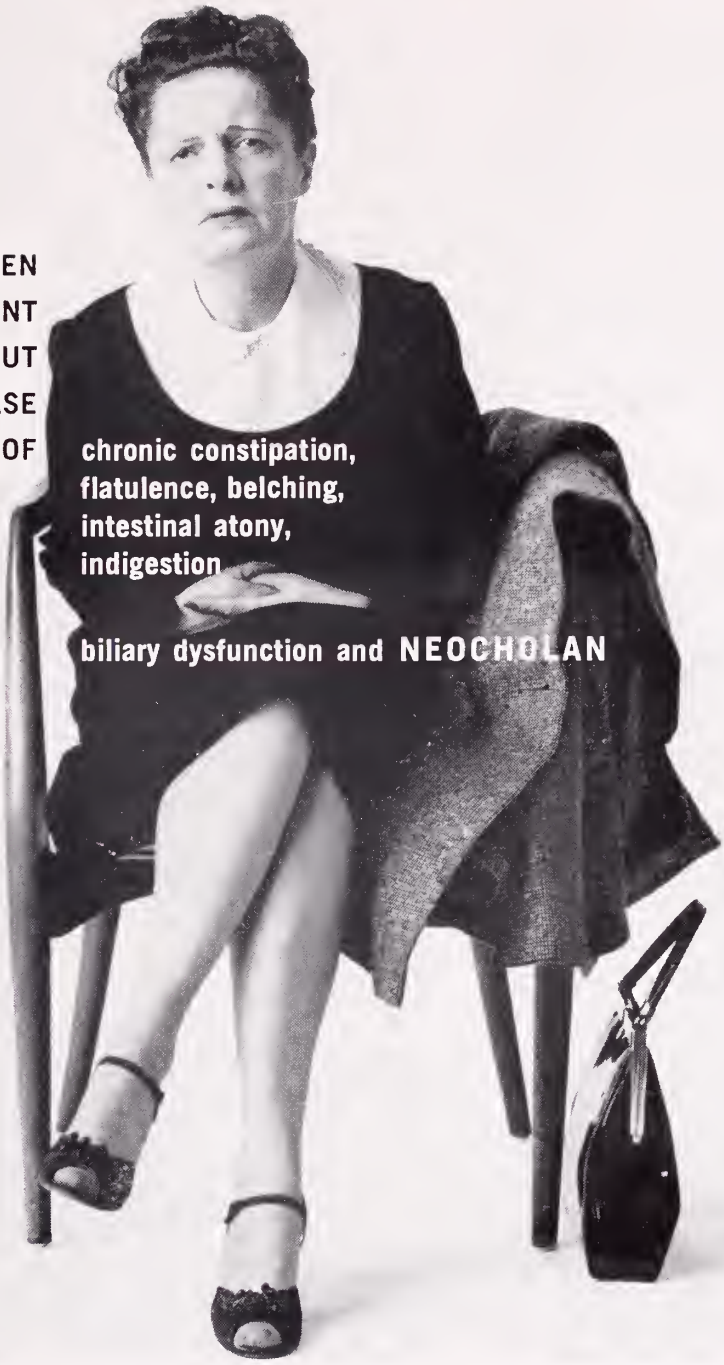
Doctor Orr advocated the AMA's positive eight-point program for the health care of the aged as a "sensible, economical" plan that would preserve freedom as well as promote security. If both these objectives are to be realized, Doctor Orr said, health care programs for the aged "must necessarily be limited to support for the needy aged and leave to voluntary, competitive, private enterprise, those activities needed to improve the health care of the rest."

### Senator Goldwater Opposes Bill

A Republican lawmaker, Sen. Barry Goldwater of Arizona, denounced the Administration's plan as "socialized medicine" and a "dime store new deal." The outspoken conservative predicted its ultimate cost would be "staggering." He said the Administration could have done better by proposing "full deductions for taxes for any amount spent for medical care of anyone" and for full costs of health plans by either an individual or corporation.

In endorsing the Administration's plan, Vice President Nixon charged the Forand-type proposals backed widely by Democrats would "open the door for socialized medicine." He said:

"The Forand Bill and similar plans would set up a great state program which inevitably would head in the direction of herding the ill and elderly into institutions whether they desired this or not. Such a state program would threaten the high standards of American medicine."



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# Obituaries

### GEORGE PHILLIPS EVANS, M. D.

Dr. George Phillips Evans, 77, of Largo, Florida, died at his home in that city on April 25, 1960.

Doctor Evans was born at Blossburg, Pennsylvania, on September 7, 1882. He received his M. D. degree from the College of Physicians and Surgeons of Baltimore in 1908, and served his internship at the Sheltering Arms Hospital in Hansford. He was licensed to practice in West Virginia in 1909 and located at Layland in Fayette County. He moved to McDowell County about 40 years ago and engaged in practice at Iaeger for more than twenty years.

He served for several months as superintendent of the Andrew S. Rowan Memorial Home at Sweet Springs and then moved to Florida, where he resided until his death.

Doctor Evans served several terms as a member of the House of Delegates from McDowell County and was for several years chairman of the House Committee on Health.

He was an honorary member of the McDowell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

He is survived by a son, Dr. George P. Evans, Jr., of Largo, Florida.

* * * *

### EDGAR B. LeFEVRE, M. D.

Dr. Edgar B. LeFevre, 79, of Inwood, Berkeley County, West Virginia, died at a hospital in Martinsburg on May 14, 1960.

Doctor LeFevre was born at Bunker Hill on August 8, 1880, son of the late Otha Brown and Katherine Virginia (Kilmer) LeFevre. He attended Stonewall Academy, better known as the "Session House" in Gerardstown, and Potomac Valley Academy at Romney. He graduated from West Virginia University and received his M. D. degree from the University of Maryland School of Medicine in 1905 and located at Davis. He moved to Inwood in 1907 where he continued in active practice until a few days before his death.

His wife, the former Frances Hamilton Henshaw, whom he married in 1908, preceded him in death.

He is survived by a daughter, Mrs. William Gold of Baltimore, and a son, E. B. LeFevre, Jr., of Martinsburg.

* * * *

### JAMES KENNEDY STEWART, M. D.

Dr. James Kennedy Stewart, 59, of Wheeling, died at his home in that city on April 29, 1960. Death was attributed to a heart attack. He had suffered an attack


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while vacationing in Florida in April, but had apparently recovered since his return home.

Doctor Stewart was born in Wheeling, March 27, 1901, son of William C. and Martha (Kennedy) Stewart. He received his B.S. degree from West Virginia University in 1927 and his M.D. degree from Jefferson Medical College of Philadelphia in 1929. He served his internship at the Ohio Valley General Hospital in Wheeling and had postgraduate work in EENT at the University of Pennsylvania Hospital in Philadelphia.

He became a member of the staff of the Wheeling Clinic in 1933 and had been associated with the Clinic since that time.

Doctor Stewart served with the Medical Corps of the Navy during World War II, being released with the rank of Captain.

He was a member of the Ohio County Medical Society, the West Virginia State Medical Association and the American Medical Association. He was a Fellow of the American College of Surgeons and a Diplomate of the American Board of Ophthalmology and Otolaryngology.

Besides his widow, the former Lou Wilson, he is survived by three daughters, Ellen, Nancy K. and Jane W., all of Wheeling; and a brother, W. C. Stewart of Westfield, New Jersey.

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He is a great man who accepts the lemons that fate hands him, and uses them to start a lemonade stand.—Norfolk & Western Magazine.

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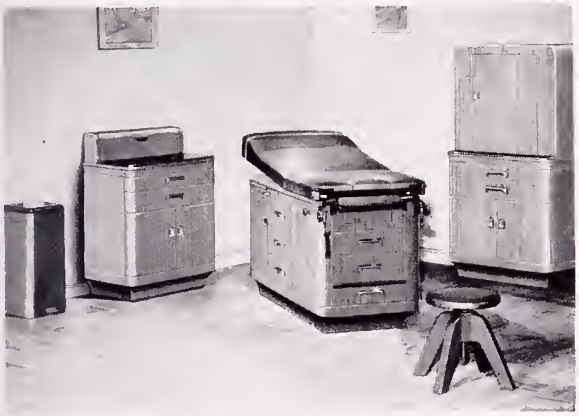

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# County Societies

### BARBOUR-RANDOLPH-TUCKER

Dr. James H. Walker of Charleston was the guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker Medical Society which was held at the Philippi Inn in Philippi on April 21.

Doctor Walker spoke on the subject of "Present Management of Pulmonary Tuberculosis." He outlined recent surgical and medical approaches to institutional therapy of this disease, and included the possibility of patient-home care in selected cases.

Dr. J. L. Rittmeyer, the president, presided at the business session following the scientific program. More than thirty members of the Society attended the meeting.—Charles L. Leonard, M. D., Secretary.

* * * *

### CENTRAL WEST VIRGINIA

Harley B. Reger of Clarksburg, rehabilitation counselor for the Division of Vocational Rehabilitation, was the guest speaker at a meeting of the Central West Virginia Medical Society and Auxiliary held at the First Methodist Church in Weston on April 28.

Mr. Reger, who is president of the National Rehabilitation Counseling Association, presented an interesting address on the "Rehabilitation Program of West Virginia."

Dr. John E. Echols of Richwood, the president, presided at the dinner meeting. Physicians and their wives were guests at an open house preceding the meeting at the home of Dr. and Mrs. E. A. Trinkle.

During the business meeting, Doctor Echols reappointed all the chairmen of standing committees, and the following delegates and alternates were named for the annual meeting of the State Medical Association at The Greenbrier in August:

Delegates, Drs. Ira F. Hartman, Buckhannon, Theresa O. Snaith, Weston, Edward H. Hunter, Richwood, and Jane Freeman, Buckhannon. Alternates, Drs. W. W. Huffman, Gassaway, C. R. Davisson, Weston, Elden H. Pertz, Weston, and George Edmiston, Webster Springs.

The Society voted to contribute $60 to Camp Kno-Koma, a camp for diabetic children. Reports were also presented on the DPA program in the state and the social security survey conducted recently among members of the Association.

Dr. R. L. Chamberlain of Buckhannon reported that arrangements are being made for the Society's Postgraduate Day program which will be held later in the year.—Jane Freeman, M. D., Secretary.

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### EASTERN PANHANDLE

The regular monthly dinner meeting of the Eastern Panhandle Medical Society was held at the Shenandoah Hotel in Martinsburg on April 13, 1960.


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The highlight of the meeting was an interesting panel discussion by members of the staff of the Newton D. Baker VA Hospital. The subject was "Diseases of the Lung," and illustrative x-ray films were shown in connection with the program. The panelists were Drs. Pierre Toulou, John Paul and T. S. Jennings.

The president, Dr. George F. Pugh, presided at the meeting, which was attended by 21 members.

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Dr. Mearle F. Stanton of Bethesda, Maryland, was the guest speaker before the regular monthly meeting of the Eastern Panhandle Medical Society which was held in Martinsburg on May 11.

Doctor Stanton, a pathologist with the National Institutes of Health, presented an interesting paper on "Tumor Progression."

The scientific program was preceded by a joint dinner and cocktail hour with members of the Woman's Auxiliary.—F. A. Hamilton, Jr., M. D., Secretary.

* * * *

**HARRISON**

Dr. John Schneider of Pittsburgh was the guest speaker at the regular monthly meeting of the Harrison County Medical Society held at the Stonewall Jackson Hotel in Clarksburg on May 5. His subject was "Medical Complications of Pregnancy."

The Legislative Committee was directed to prepare proposed changes in the Constitution and By-Laws so that the annual year would begin in May instead of December. This matter will be discussed at the next meeting of the Society.

The president, Dr. Richard V. Lynch, Jr., announced that Drs. George F. Evans and J. E. Wilson, Jr. have been named as members of the Interprofessional Liaison Committee between the Harrison County Medical Society and the Harrison County Bar. Mr. Oscar A. Andre and Mr. Rupert Sinsel are the legal representatives.

Doctor Lynch also announced the appointment of a Committee on Aging. Doctor Weaver is the chairman and the other members are Drs. L. Dale Simmons and James G. Ralston.—Andrew J. Weaver, M. D., Secretary.

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**RALEIGH**

Dr. Leonard J. Goldner, Professor of Orthopedics at Duke University School of Medicine, was the guest speaker before the regular monthly meeting of the Raleigh County Medical Society, held at the El Chico Cafe in Beckley on April 21. He discussed the carple tunnel syndrome and the management of acute hand injuries.

At the business meeting following the scientific program, it was ordered that the sum of $500 be appropriated for the American Medical Education Foundation, and that the contribution be earmarked for the WVU School of Medicine.

The Society also voted to contribute the sum of $120 for Camp Kno-Koma. The president, Dr. F. Vivan Lilly, announced the appointment of Dr. Edward M. Schneider as co-chairman of the committee on aging.—Preston C. Davis, M. D., Secretary.

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**WEST VIRGINIA STATE MEDICAL ASSOCIATION**

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*President Elect:* Mrs. Clark K. Sleeth, Morgantown
*First Vice President:* Mrs. V. L. Dyer, Petersburg
*Second Vice President:* Mrs. Myer Bogarad, Weirton
*Third Vice President:* Mrs. John F. Morris, Huntington
*Fourth Vice President:* Mrs. P. A. Tuckwiller, Charleston
*Treasurer:* Mrs. George A. Curry, Morgantown
*Recording Secretary:* Mrs. Rupert W. Powell, Fairmont
*Corresponding Secretary:* Mrs. James W. Hamilton, Marlinton
*Parliamentarian:* Mrs. J. Preston Lilly, Charleston

### GREENBRIER

More than twenty persons attended the April luncheon meeting of the Woman's Auxiliary to the Greenbrier Valley Medical Society which was held at the home of Dr. and Mrs. Eugene McClung in Lewisburg.

Mrs. Lee B. Todd of Quinwood, the president, presided at the meeting and a report was presented on the Nurses' Scholarships Program.

Mrs. Eugene J. Morhous of White Sulphur Springs, who is general chairman of the Annual Meeting of the State Auxiliary which will be held at The Greenbrier in August, outlined the program that has been arranged. Mrs. Robert R. Pittman of Marlinton, the the State President, also attended the meeting.—Mrs. James W. Hamilton, Correspondent.

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### HARRISON

Mrs. Herman Fischer was installed as president of the Woman's Auxiliary to the Harrison County Medical Society at a dinner meeting held at the Stonewall Jackson Hotel in Clarksburg on May 5. Other new officers are as follows:

Mrs. Bernard W. Wilkinson, president elect; Mrs. Charles S. Harrison, vice president; Mrs. Paul E. Gordon, secretary; and Mrs. John D. H. Wilson, treasurer.

Mrs. James A. Thompson, the retiring president, presided at the business session and the new officers were installed by Mrs. John F. McCuskey, past president of the county and state auxiliary.

Following the business session, a Chinese auction was held and the proceeds were contributed to the American Medical Education Foundation.—Mrs. Paul E. Gordon, Correspondent.

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### MARION

Mrs. John D. Lindsay, Jr., of Fairmont, was elected president of the Woman's Auxiliary to the Marion County Medical Society at a meeting held at her home on April 26. Other new officers are as follows:

Mrs. J. J. Jenkins, Jr., president elect; Mrs. Merle B. Davis, vice president; Mrs. Robert G. Janes, secretary; and Mrs. O. L. Haynes, treasurer.

Mrs. John P. Helmick, a past president of the State Auxiliary, installed the new officers. Mrs. O. M. Good-

win, the retiring president, presided at the meeting and gave a resume of the work accomplished during the past year.

Mrs. Seigle W. Parks presented a report as chairman of the Revisions Committee and other reports were given on AMEF, Civil Defense, Legislation and Nurse Recruitment.

Mrs. Claude S. Lawson, Jr., immediate past president, presented Mrs. Goodwin with a silver bowl in appreciation of her outstanding work as president of the Auxiliary.—Mrs. William T. Lawson, Correspondent.

* * * *

**McDOWELL**

The Woman's Auxiliary to the McDowell County Medical Society sponsored a tea for "Future Nurses" from all McDowell County high schools at the Appalachian Community Room in Welch on April 20.

Mrs. Hendrick A Bracey, superintendent of nurses at Stevens Clinic Hospital, was the speaker and she presented an interesting and informative talk on the advantages of a nursing career. She discussed the great demand for nurses now and in the future, and outlined the many factors involved in preparing for a nursing career.

Mrs. Dante Castrodale, the president, presided at the meeting and Mrs. J. Howard Anderson and Mrs. H. T. Schiefelbein were in charge of arrangements.

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The annual "Doctors' Day" observance, sponsored by the Woman's Auxiliary to the McDowell County Medi-


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**Obstetrics and Gynecology:**
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James A. Jacob, Jr., M. D.

**Neurology and Psychiatry:**
Albert L. Wanner, M. D.

**Roentgenology:**
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Roentgenology:
Evelyn Forester, R. T.

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cal Society, was held at the "Cow Shed" in Pineville on April 21. Mrs. Dante Castrodale, the president, presided at the dinner meeting which was preceded by a social hour.

The program included a recitation of the "Physician's Prayer" by Mrs. George L. Fischer, and an address of welcome by Mrs. Castrodale. Dr. Guy E. Irvin, president of the Medical Society, responded on behalf of that group.

Mrs. A. B. Carr spoke on the subject of "The Red Carnation-Symbol of Doctors' Day," and Mrs. Charles B. Chapman discussed "The History of Doctors' Day."

More than fifty physicians and their wives attended the dinner meeting.—Mrs. J. H. Smith, Correspondent.

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**MERCER**

Mrs. Robert R. Pittman of Marlinton, President of the Woman's Auxiliary to the West Virginia State Medical Association, was the guest speaker at the April luncheon meeting of the Woman's Auxiliary to the Mercer County Medical Society which was held at the Bluefield Country Club in that city.

Mrs. Pittman spoke on the subject of "Work on the State Level," and she outlined plans that are being made to care for our elderly citizens. She also pointed out the great need for more contributions to the American Medical Education Foundation.

Mrs. Gordon L. Todd, Jr., the president, presided at the meeting. She announced that a tea honoring new members and officers would be held at her home in Princeton in May.—Mrs. Robert S. Gatherum, Jr., Correspondent.

* * * *

**MINGO**

Mrs. W. H. Price was elected president of the Woman's Auxiliary to the Mingo County Medical Society at the regular monthly luncheon meeting held at the Mountaineer Hotel in Williamson on April 28. She will succeed Mrs. W. W. Scott.

Mrs. R. A. Salton was elected president elect; Mrs. W. J. Smith, vice president; and Mrs. Frank J. Burian, treasurer. Mrs. Robert J. Tchou was renamed recording and corresponding secretary.

New officers will be installed at the final meeting of the current year which will be held in May. The new president will name committees at that time.

The president, Mrs. Scott, presided at the meeting and hostesses were Mrs. Clarence G. Rayburn and Mrs. Paul A. Keeney.—Mrs. Robert Tchou, Correspondent.

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**MONONGALIA**

Mrs. Clement A. Smith was installed as president of the Woman's Auxiliary to the Monongalia County Medical Society at a luncheon meeting which was held at the Lakeview Country Club in Morgantown on May 3. Other new officers are as follows:

Mrs. John H. Trotter, president elect; Mrs. Enrico Paparozzi, vice president; Mrs. Robert Greco, treasurer; Mrs. French R. Miller, recording secretary; Mrs.


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Arthur W. Kelley, corresponding secretary; and Mrs. Hubert A. Shaffer, parliamentarian.

Mrs. Shaffer, the retiring president, presided at the business session which included progress reports by the chairmen of various committees. A gift in the form of a donation to AMEF was presented to Mrs. Shaffer by Mrs. Edward J. Van Liere, in appreciation of her work as president during the past year.

Mrs. Vernon L. Dyer of Petersburg, Regional Director, was an honor guest at the meeting. Hostesses were Mrs. Robert J. Fleming, chairman, and Mesdames Milford Hobbs and J. W. Hesen, Jr.—Mrs Hubert T. Marshall, Publicity Chairman.

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**OHIO**

Mrs. Robert T. Bandi of Wheeling was elected president of the Woman's Auxiliary to the Ohio County Medical Society at a luncheon meeting held on April 23. She succeeds Mrs. John G. Thoner, the retiring president.

Other officers elected were as follows: Mrs. Andrew K. Butler, president elect; Mrs. George M. Kellas, vice president; Mrs. J. Speed Rogers, recording secretary; Mrs. Harry S. Weeks, Jr., corresponding secretary; and Mrs. Herbert G. Dickie, Jr., treasurer.

Hostesses for the luncheon were Mrs. L. A. Lyon, chairman, and Mesdames Louis B. Farri, C. J. Holley, R. Alan Fawcett, Edward Armbrecht and Robert T. Brandfass.

It was announced that the new officers will be installed at the May meeting of the Auxiliary, and that officers of the State Auxiliary will be honor guests.—Mrs. Robert Robbins, Publicity Chairman.

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**PARKERSBURG**

Dr. James L. Wade was the guest speaker at a luncheon meeting of the Woman's Auxiliary to the Parkersburg Academy of Medicine which was held at the Hotel Chancellor in Parkersburg on April 12.

Doctor Wade, who is a member of the Board of Directors of the Wood County Mental Health Association, presented an interesting talk on the subject of mental illness. He said "mental illness causes more suffering, anguish and expense than any other physical ailment."

He said that today mental patients fill more than half of the hospital beds in this country. He also emphasized that there was nothing shameful or disgrace-


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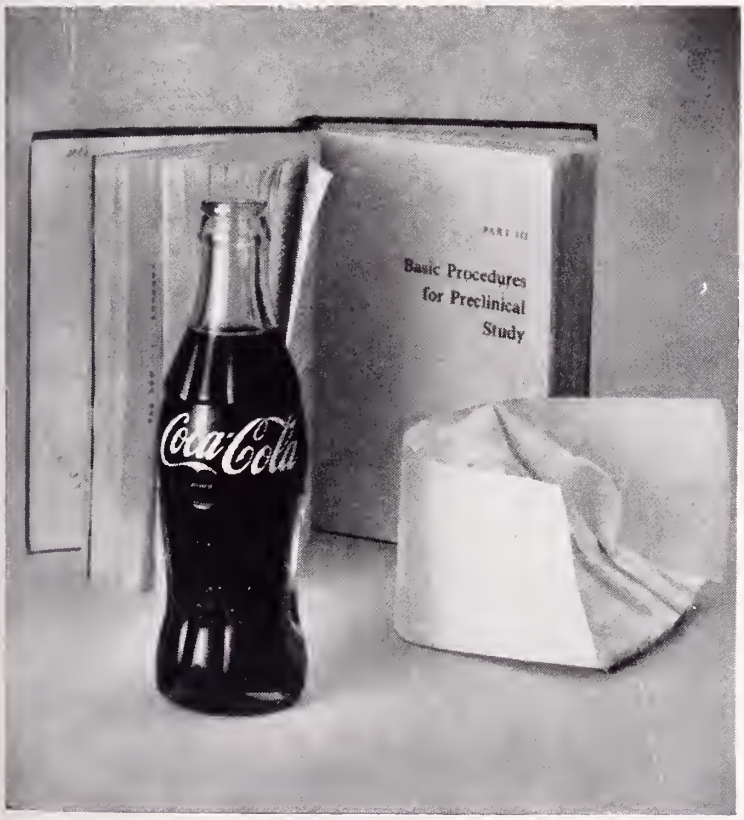


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ful about such an illness, although most people hesitate to even discuss it.

Mrs. Charles L. Goodhand, first vice president of the Woman's Auxiliary to the American Medical Association, presented a report on the Regional Conference on Aging which was held recently in Baltimore, and Mrs. Dwight P. Cruikshank reported on Auxiliary activities in connection with the medical profession's opposition to Forand-type legislation.

Mrs. Edward Shupala, the president, presided at the meeting, and Mrs. A. M. Jones was in charge of arrangements.—Mrs. George Gevas, Correspondent.

### Pre-Medical Education

When I was a postgraduate student in Berlin before the first world war, Waldeyer, the Grand Old Man of German anatomy, used to invite some of his students to share a Sunday walk with him. On one such *Ausflug*, I ventured to ask him: "Which type, Professor, do you think makes the best doctor—the student who comes to the university from a *Technische Hochschule*, or the one who has had a good grounding in the Humanities?" Without hesitation the old man replied: "Give me the student who has done his Humaniora, every time. The knowledge of literature—and in that I include history—makes its possessor a wiser man; it is the most necessary quality for the doctor in practice."—William Doolin, M. D., in The Lancet.

To me, old age is always 15 years older than I am.—Bernard Baruch.

# Book Reviews

**BIOPSY MANUAL—By James D. Hardy, M. D., Professor and Chairman of the Dept. of Surgery, James C. Griffin, Jr., Asst. Instructor in Surgery, Administrative Chief Resident in Surgery, National Cancer Institute Trainee, and Jorge A. Rodriguez, M. D., Assistant Professor of Surgical Anatomy, The Dept. of Surgery, all of the University of Mississippi School of Medicine. Pp. 150 with 54 illustrations. Philadelphia and London: W. B. Saunders Company. 1959. Price $6.50.**

This is a very elementary presentation of the numerous problems that the obtaining of biopsies may entail. It was written by surgeons primarily for medical students and interns.

The first chapter presents general considerations with references to biopsies, i. e., uses, types, complications, errors, techniques, clinical data needed by the pathologist, and the value of a frozen section versus the value of a paraffin section.

The second chapter is devoted to biopsy instruments and to various fixatives. The remaining nine chapters are devoted to a fairly detailed description of biopsy techniques and complications presented by anatomical regions.

This work presents in a concise manner much basic information extremely valuable to the young physician. The manual would make a valuable addition to the library of the hospitals responsible for this training.—John B. Harley, M. D.

* * * *

**I PRESCRIBE LAUGHTER—By Thomas Richard Rees, M. D., Washington, D. C. Pp. 111. Vantage Press, Inc., 120 W. 31 Street, New York 1, N. Y. 1960. Price $2.75.**

After months of reading a variety of scientific publications for review, the appearance of this rather humorous volume constituted a welcome and entertaining interlude. The contents vary from bits of verse and stories containing the unconscious sense of timing and humor of children to some more or less earthy tales.

Some of the stories are old, some new, and some no doubt original with the author. I especially liked the


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old one in which Chauncey Depew described ideal conditions for sleep.

I cannot conceive of any physician increasing his therapeutic armamentarium through the purchase and perusal of this book, but it will take the edge off many a trying day.—James S. Klumpp, M. D.

* * * *

**NEUROSURGERY, VOLUME II (Most recently published volume in the series of the official History of the Medical Department, United States Army, in World War II—Prepared and published under the direction of Major General S. B. Hays, the Surgeon General, USA; Editor in Chief, Colonel John Boyd Coates, Jr., (MC); Editors for Neurosurgery, R. Glen Spurling, M. D., and Barnes Woodhall, M. D.; Associate Editor, Elizabeth M. McFetridge, M. A. Pp. 705, with 23 illustrations, 12 color plates, and 15 tables. Superintendent of Documents, Washington 25, D. C. 1959. Price $7.00.**

This second and final volume in the Neurosurgical series of World War II deals with injuries and diseases of the spine and peripheral nerve injuries. It is a rather large, compact volume of 705 pages containing a large amount of pertinent and helpful neurosurgical information.

Part I consists of eight chapters on Injuries of The Spinal Cord and Part II continues with chapters IX through XXIII on Peripheral Nerve Injuries. There are six appendices, 283 illustrations, 12 color plates, and 15 tables. Pages 651 to 705, inclusive, comprise an extensive index.

In addition to being an interesting history of the care of patients with spinal cord and nerve injuries by the members of the Medical Corps of the U. S. Army during World War II, the chapters in this volume furnish an excellent text to which one can refer for more minute details in neurosurgical management and technique. The reproductions of photographs and the line drawings used to illustrate the discussions are well chosen and well reproduced. The arrangement and format of Volume II maintains the high standard set by Volume I in this series, and it admirably completes the two-volume set of Neurosurgery in World War II.

Certainly, those who have Volume I of this series will be anxious to acquire this second volume for their reading and their libraries. To those who are not acquainted with either volume the reviewer recommends both.—E. Lyle Gage, M. D.

* * * *

**DRUGS OF CHOICE 1960-1961—By Walter Modell, M. D., Director, Clinical Pharmacology, and Associate Professor of Pharmacology, Cornell University Medical College; Attending Physician, New York Veterans Administration Hospital; Associate Visiting Physician, Bellevue Hospital; Member, Poison Control Advisory Board of New York City; Member, Revision Committee, United States Pharmacopeia XVI and Editor, Clinical Pharmacology and Therapeutics. Pp. 958. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Missouri. Second Edition. 1960. Price $13.50.**

After the universal acceptance of the first edition of this work the editor and publisher have selected an interval of two years as a logical period before revision. The second edition is well timed and will prove to be quite useful. New topics have been added. The names

## OFFICERS OF COMPONENT SOCIETIES

| Society | President | | Secretary | | Meetings |
|---|---|---|---|---|---|
| Barbour-Randolph-Tucker | Samuel C. Johnson | Parsons | Charles L. Leonard | Elkins | 3rd Thurs. |
| Boone | James M. Scott | Madison | H. H. Howell | Madison | 2nd Wed. |
| Brooke | James E. Wise | Follansbee | H. L. Hegner | Wellsburg | |
| Cabell | I. Ewen Taylor | Huntington | W. L. Neal | Huntington | 2nd Thurs. |
| Central West Virginia | John E. Echols | Richwood | Jane Freeman | Buckhannon | As Scheduled |
| Eastern Panhandle | George F. Pugh | Martinsburg | F. A. Hamilton, Jr. | Martinsburg | Quarterly |
| Fayette | Thomas C. Sims | Longacre | Marvin Kirsh | Montgomery | 1st Wed. |
| Greenbrier Valley | E. T. Cobb | Ronceverte | James Hamilton | Marlinton | 2nd Wed. |
| Hancock | George Naymick | Weirton | Arthur Phillips | Weirton | 2nd Tues. |
| Harrison | Richard V. Lynch, Jr. | Clarksburg | Andrew J. Weaver | Clarksburg | 1st Thurs. |
| Kanawha | Milton J. Lilly | Charleston | A. B. Curry Ellison | Charleston | 2nd Tues. |
| Logan | Ray M. Kessel | Logan | Luke Combs | Man | 2nd Wed. |
| Marion | J. David Lindsay, Jr. | Fairmont | G. Thomas Evans | Fairmont | Last Tues. |
| Marshall | H. B. Ashworth | Moundsville | J. W. Myers | Moundsville | Semi-Ann. |
| Mason | C. Leonard Brown | Pt. Pleasant | Dan Glassman | Pt. Pleasant | |
| McDowell | Guy E. Irvin | Welch | George L. Fischer | Welch | 2nd Wed. |
| Mercer | W. E. Copenhaver | Bluefield | John J. Mahood | Bluefield | 3rd Mon. |
| Mingo | Frank J. Burian | Williamson | Russell A. Salton | Williamson | 2nd Thurs. |
| Monongalia | David Z. Morgan | Morgantown | C. A. Logue | Morgantown | 1st Tues. |
| Ohio | S. S. Bobes | Wheeling | H. G. Dickie | Wheeling | 4th Tues. |
| Parkersburg Academy | Jack J. Stark | Belpre, Ohio | Robert M. Biddle | Parkersburg | 1st Thurs. |
| Potomac Valley | P. R. Wilson | Piedmont | H. L. Eye | Franklin | 2nd Wed. |
| Preston | John F. Lehman | Kingwood | C. Y. Moser | Kingwood | 4th Thurs. |
| Raleigh | F. Vivan Lilly | Beckley | Preston C. Davis | Beckley | 3rd Thurs. |
| Summers | Jack D. Woodrum | Hinton | A. W. Holmes | Hinton | 3rd Wed |
| Taylor | R. D. Stout | Grafton | Herbert N. Shanes | Grafton | Last Thurs. |
| Wetzel | Lemoyne Coffield | New Martinsville | C. P. Watson, Jr. | New Martinsville | Monthly |
| Wyoming | E. M. Wilkinson | Pineville | R. E. Newman | Mullens | Quarterly |

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The book, which is recommended for use by any active practitioner, constitutes a noble attempt to separate the chaff from the wheat for the harried practitioner.—John B. Harley, M. D.

## Books Received

**"NINE MONTHS' READING—A MEDICAL GUIDE FOR PREGNANT WOMEN."**—By Robert E. Hall, M. D., Obstetrician and Gynecologist at Sloane Hospital for Women, a Division of the Columbia-Presbyterian Medical Center, New York City. Pp. 191, with illustrations. Doubleday & Company, Inc., 575 Madison Avenue, New York 22, New York. 1960. Price $2.95.

* * * *

**FIRST AID: DIAGNOSIS AND TREATMENT**—By Warren H. Cole, M. D., Professor and Head of the Department of Surgery, University of Illinois College of Medicine, Chicago, and Charles B. Puestow, M. D., Clinical Professor of Surgery, University of Illinois College of Medicine and Graduate School. Pp. 420, with numerous illustrations. Fifth Edition. Appleton-Century-Crofts, Inc., 35 West 32nd Street, New York 1, N. Y. 1960. Price $6.25.


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**CLINICAL MANAGEMENT OF BEHAVIOR DISORDERS IN CHILDREN**—By Harry Bakwin, M. D., Professor of Clinical Pediatrics, New York University, visiting physician, Bellevue Hospital, and attending pediatrician, University Hospital; and Ruth Morris Bakwin, M. D., Associate Professor Clinical Pediatrics, New York University, visiting physician, Bellevue Hospital, and Director Emeritus, Department of Pediatrics, New York Infirmary. Pp. 597, with illustrations. Second Edition. Philadelphia and London: W. B. Saunders Company. 1960. Price $11.00.

* * * *

**WOMAN AND FATIGUE—A WOMAN DOCTOR'S ANSWER**—By Marion Hilliard, M. D., Chief of Obstetrics and Gynecology, Women's College Hospital, Toronto, Canada. Pp. 175. Doubleday & Company, Inc., 575 Madison Avenue, New York 22, N. Y.

* * * *

**MEDICAL, SURGICAL AND GYNECOLOGICAL COMPLICATIONS OF PREGNANCY**—By the Staff of The Mount Sinai Hospital, New York City. Edited by Alan F. Guttmacher, M. D., Obstetrician and Gynecologist-in-Chief, The Mount Sinai Hospital, New York; and Joseph J. Rovinsky, M. D., Assistant Attending Obstetrician and Gynecologist, The Mount Sinai Hospital, New York. Pp. 619, with illustrations. The Williams & Wilkins Company, Baltimore 2, Md. 1960. Price $16.50.

* * * *

**FUNDAMENTALS OF CLINICAL HEMATOLOGY**—By Byrd S. Leavell, M. D., Professor of Internal Medicine, Physician in Charge, Hematology Section, University of Virginia School of Medicine, and Attending Physician at University of Virginia Hospital; and Oscar A. Thorup, Jr., M. D., Associate Professor of Internal Medicine, University of Virginia School of Medicine, and Attending Physician at the University of Virginia Hospital. Pp. 503, with illustrations. Philadelphia & London: W. B. Saunders Company. 1960. Price $10.

* * * *

**THE TEEN-AGE YEARS**—By Arthur Roth, M. D., founder and director of the Teen-Age Clinic at the Foundation Medical Center in Oakland, California. Pp. 288. Doubleday and Company, 575 Madison Avenue, New York 22, New York. 1960. Price $3.95.

## Arbitrary Retirement Not Realistic

In the more advanced society of our times, with increased population, increased economic conflict and increased competition for work opportunities, there has been some restriction on individuals working after sixty-five years of age on the allegation that they were not very productive. This is a serious social problem. Apparently even the prodigious enterprises of the country cannot employ all of its citizens. Arbitrary retirement at any particular age is not realistic.

Aging persons do not like to be classified as belonging to an old age group on the basis of their years alone. While some old persons may be somewhat disabled because of illness, there are many aging persons who are in good health. The dependency of the aging has been overstressed and the cultural contributions which old age can make have been undervalued. If aging persons could be kept integrated with other individuals of all ages in the family and at work, it would contribute much to their feeling of security.—Charles Sellers in Journal, Michigan State Medical Society.

There is a lot of talk about giving the aged relief. After 65, a relief in taxes on the homesite might allow these people to keep their home intact and not make them wanderers.—Detroit Medical News.

JULY
1960

Vol. 56 No. 7

# The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Huntington

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Charleston

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone Dickens 4-4625.

Member 1960

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Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. *80*:481 (Oct.) 1958. 2. Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 3. Mathews, F. P.: Am. J. Psychiat. *114*:1034 (May) 1958.

SEARLE

# WVU Medical Center
# —News—

• Compiled from moteriol furnished by John B. Horley, M. D., Assistont Professor of Pothology ond Public Informotion Officer at the WVU Medicol Center in Morgontown, W. Vo.

SIXTEEN students will enroll this fall as members of the first third-year class at the West Virginia University School of Medicine. Dr. E. J. Van Liere, Dean, announced that fifteen members of the second-year class will continue their education at the Medical College of Virginia in Richmond, and three at the University of Pennsylvania School of Medicine, Philadelphia.

Two members of the second-year class, Stanley B. Gross of Weirton and James L. Schmidt of Clarksburg, have elected to interrupt their medical curriculum for one year of post-sophomore research.

Those who will enter the third-year class at the WVU School of Medicine are as follows:

Richard B. Arnold, Huntington; Halbert E. Ashworth, Charleston; Frederick M. Cooley, Nitro; Basil D. Cutlip, Jr., Webster Springs; Francis A. Goad, Clendenin; Jesse S. Griffith, Charleston; Louis W. Groves, Meadow Bridge; Ira L. Hemmings, Jr., Charleston; Charles L. Ladwig, Clarksburg; Charles W. Lewis, Huntington; George H. Nelson, Morgantown; Joseph B. Reed, Burlington; Joseph Ruggiero, Fairmont; Kenneta J. Shaffer, Morgantown; Watson G. Watring, Beverly; and David L. White, Bridgeport.

The following students will enter the Medical College of Virginia:

John L. Barile, Clarksburg; Robert L. Bowman, Fairmont; Dominic Gaziano, Pemberton; Jon L. Jordan, Oak Hill; William G. Jordan, Oak Hill; Marguerite A. Kern, Welch; Azett J. Mosrie, Princeton; Hubert V. Moss, Weirton; Spottswood P. Neale, Princeton; Richard Rashid, Charleston; William H. Schmid, Benwood; Ida May H. Steele, Montgomery; James L. Steele, Bartley; Pete L. Stephens, Weirton; and Edward A. Zakaib, Charleston.

The following three students will transfer to the University of Pennsylvania School of Medicine: Joseph H. Calhoun of Moorefield, William K. Harris of Morgantown and Thomas J. Nassif of Rowlesburg.

### Honor Students Named

Dr. Clark K. Sleeth, Assistant to the Dean, announced recently the names of the seven students who achieved the highest academic ranking following the first two years of study in the School of Medicine.

The three top students will continue their medical training at the WVU School of Medicine. They are George H. Nelson, Morgantown, Joseph Ruggiero, Fairmont, and Francis A. Goad, Clendenin.

The other four honor students are Richard Rashid, Charleston, Dominic Gaziano, Pemberton, Jesse S. Griffith, Charleston, and William K. Harris, Morgantown.

In addition to those named above, Doctor Sleeth also said the following second-year students were named to the Dean's List for the second semester of the current year: Frederick M. Cooley, Nitro, Basil D. Cutlip, Jr., Webster Springs, Ira L. Hemmings, Charleston, Hubert V. Moss, Weirton, Thomas J. Nassif, Rowlesburg, and James L. Steele, Bartley.

The following first-year students were named to the Dean's List: John L. Fullmer, Reedsville, Robert R. Gustke, Parkersburg, James E. Kopp, Clarksburg, Ricci J. Larese, Kimball, Lowell T. Mouser, Minnehaha Springs, Richard D. Richmond, Beckley, and David E. Wallace, Madison.

### Installing Hospital Furniture

Thirteen students in the School of Medicine have been employed during the summer months to help commission 200 beds in the Teaching Hospital. This work will help acquaint the students with the facility and the personnel at the hospital and will expedite the clinical training of the third-year students in the fall inasmuch as they will already be familiar with the organization of the hospital.

Departmental personnel are now working out systems of organization and standardization. The general cleaning process of the hospital was undertaken early in June. It is anticipated that the first hospital patients will be admitted on or about August 1.

### Faculty Members Attend Meeting

Four members of the faculty of the School of Medicine presented papers at the annual meeting of the Federation of American Societies for Experimental Biology, which was held recently in Chicago. Those attending the meeting were Dr. J. C. Stickney, professor of physiology, Dr. David W. Northup, chairman of the Department of Physiology, Dr. W. W. Fleming, Department of Pharmacology, and Dr. Edwin C. Gangloff, Department of Biochemistry.

Also attending the meeting from the University were Drs. R. F. Krause, William J. Canady, J. J. Lotspeich and Daniel T. Watts.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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# The Month in Washington

An omnibus bill approved by the House Ways and Means Committee contains two provisions of major importance to physicians—Social Security coverage for doctors and a federal-state program to provide care for older persons with low incomes.

About 150,000 self-employed physicians would be covered by Social Security on the same basis as lawyers, dentists and other self-employed professional people are now covered. Becoming effective for taxable years ending on Dec. 31, 1960, or June 30, 1961, self-employed physicians would be required to pay a Social Security tax of 4½ per cent of the first $4,800 of income. Physicians also would be subject to the automatic increases in the Social Security tax in future years.

Medical and dental interns would be covered for the first time also.

Rep. Wilbur Mills (D., Ark.), Chairman of the Ways and Means Committee, was the main architect of the health program for "medically indigent" aged. It was designed to provide a broad range of hospital, medical and nursing services for persons 65 years of age and older who are able financially to take care of their ordinary needs but not large medical expenses.

It would be up to each state to decide whether it participates in the program. The extent of participation —the number of benefits offered to older persons— also would be at the option of individual states.

### States Would Determine Eligibility

The states would determine the eligibility of older persons to receive benefits under the program. However, the legislation laid down a general framework for eligibility: persons 65 years and older, whose income and resources—taking into account their other living requirements—are insufficient to meet the cost of their medical care.

The program couldn't become effective until July 1, 1961. Before putting such a program into effect, a state would have to submit to the federal government a plan meeting the general requirements outlined in the legislation.

The program would be financed jointly by the federal and state governments. Federal grants would have to be matched by participating states on the same basis as under the present-old age assistance formula.

• **From the Washington Office of the American Medical Association.**

### Benefits of Program

States could elect to provide, with federal financial aid, any or all of the following benefits:

(1) Inpatient hospital services up to 120 days per year; (2) skilled nursing-home services; (3) physicians' services; (4) outpatient hospital services; (5) organized home care services; (6) private duty nursing services; (7) therapeutic services; (8) major dental treatment; (9) laboratory and X-ray services up to $200 per year, and (10) prescribed drugs up to $200 per year.

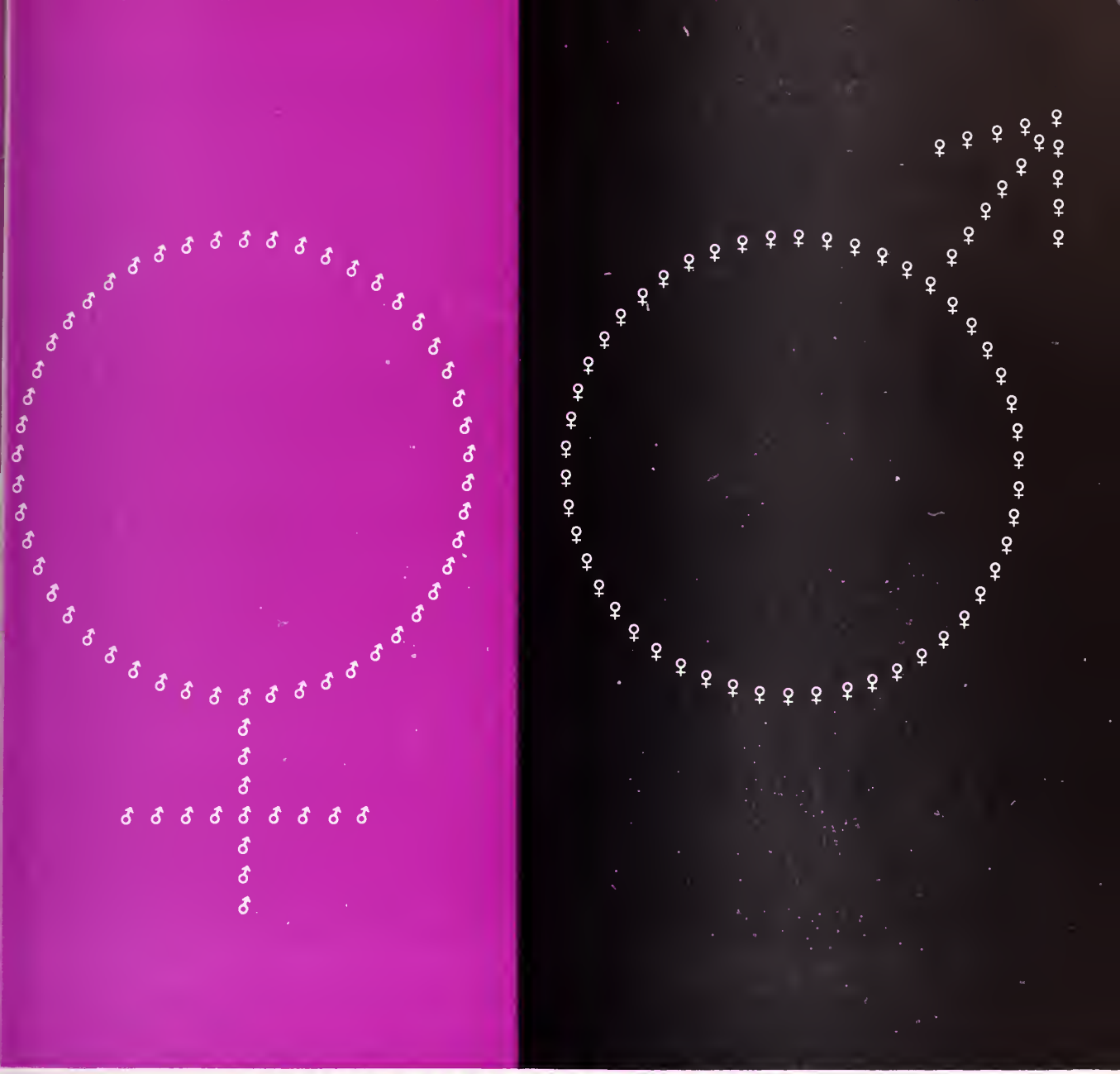
The committee put a $325 million price tag on the program for the first full year of operation—185 million federal and 140 million state. However, this estimate could hardly be more than an educated guess of sorts. The actual cost would depend upon unpredictable factors—how many states would participate, how many benefits they would offer, and how many older persons would qualify and what services they would require.

The committee estimate was based on between 500,000 and 1 million older persons a year receiving health services under the program. If all states participated fully, the committee said, potential protection would be provided for as many as 10 million aged whose financial resources are so limited that they would qualify in case of serious or extensive illness.

Payments under the program would go directly to physicians and other providers of medical, hospital and nursing services.

In addition to the federal grants for the "medically indigent," about $10 million more in federal funds would be authorized for payment to states for raising the standards of medical care benefits under present public assistance programs for older persons.

The approach of the Mills program was similar to that of Point 2 of the American Medical Association's 8-point program for health care of the aged. Point 2 stated that the AMA supports federal grants-in-aid to states "for the liberalization of existing old-age assistance programs so that the near-needy could be given health care without having to meet the present rigid requirements for indigency." Such a liberalized definition of eligibility should be determined locally, the AMA said.



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*Marmell, M., and Prigot, A.: Tetracycline phosphate complex in the treatment of acute gonococcal urethritis in men. Antibiotic Med. & Clin. Ther. 6:108 (Feb.) 1959.

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## Annual Audit, 1959

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the calendar year 1959 has been completed by the firm of Fitzhugh, Erwin, McKee and Hickman, Certified Public Accountants of Charleston. The complete audit, with letter of transmittal, follows:

**FITZHUGH, ERWIN, McKEE & HICKMAN**
**Certified Public Accountants**
**Kanawha Banking & Trust Building**
**Charleston 1, W. Va.**

West Virginia State Medical Association
Charleston, West Virginia

We have examined the records of receipts and disbursements of your Association for the year ended December 31, 1959. Summary statements of the various funds which were prepared from these records and a schedule of bonds owned at the year end date are herewith presented.

Cash in bank amounting to $38,142.26 at December 31, 1959, was reconciled with the balance confirmed by the depository bank and bonds owned by your Association at that date were verified by inspection at the safe deposit box on May 3, 1960. We did not examine petty cash disbursements.

The salary of your Executive Secretary for the year 1959 was $12,000.00, of which $9,000.00 was charged to the General Fund and $3,000.00 to the Medical Journal Fund for managing and editing the Journal.

---

In our opinion, all receipts of record of West Virginia State Medical Association for the year ended December 31, 1959, have been properly accounted for and the balance of cash in bank and bonds owned at December 31, 1959, are correctly stated herein.

FITZHUGH, ERWIN, McKEE & HICKMAN

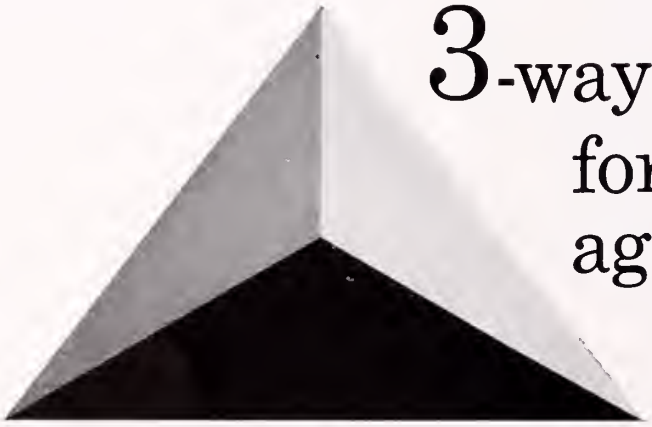
Charleston, W. Va.
May 6, 1960

### COMBINED STATEMENT OF RECEIPTS AND DISBURSEMENTS CALENDAR YEAR 1959

| | | |
|---|---|---|
| CASH IN BANK—JANUARY 1, 1959 | | $ 32,049.03 |
| RECEIPTS | | |
| Dues | $ 32,278.50 | |
| Interest on U. S. Bonds | 650.00 | |
| Collection Commission on A.M.A. Dues | 326.62 | |
| Advertising | 47,644.28 | |
| Emblems Sold | 127.00 | |
| Subscriptions | 271.72 | |
| Exhibit Space Sold | 9,215.00 | |
| Dues Collected for A.M.A. | 31,375.00 | |
| Medical Scholarship Fund Assessment | 3,838.50 | |
| Refunds | 284.49 | |
| Total Receipts | | 126,011.11 |
| | | 158,060.14 |
| DISBURSEMENTS | | |
| General Fund | 38,661.52 | |
| Medical Journal Fund | 38,737.27 | |
| Convention Fund | 9,073.12 | |
| Dues Forwarded to A.M.A. | 31,375.00 | |
| Medical Scholarship Fund | 1,500.00 | |
| Public Service Fund | 570.97 | |
| Total Disbursements | | 119,917.88 |
| CASH IN BANK—DECEMBER 31, 1959 | | $ 38,142.26 |

### GENERAL FUND
**Statement of Receipts and Disbursements**
**Calendar Year 1959**

| | | |
|---|---|---|
| BALANCE—JANUARY 1, 1959 | | $ 13,326.92 |
| RECEIPTS | | |
| Dues (Allocated to General Fund) | $ 28,255.50 | |
| Interest on U. S. Bonds | 650.00 | |
| Collection Commission on A. M. A. Dues | 326.62 | |
| Refunds—Travel Expense | 172.76 | |
| —Convention | 74.23 | |
| —A. M. A. Dues | 37.50 | |
| Transferred from Medical Journal Fund | 6,000.00 | |
| Total Receipts | | 35,516.61 |
| | | 48,843.53 |

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| | | |
|---|---|---|
| DISBURSEMENTS | | |
| Salaries (Less Payroll Taxes): | | |
| —Executive Secretary | 6,840.00 | |
| —Office | 9,752.91 | |
| Office Supplies and Expense | 1,775.95 | |
| Office Rent | 2,972.04 | |
| Library Expense | 3.35 | |
| Telephone and Telegraph | 1,223.45 | |
| Postage | 1,461.89 | |
| Travel | 4,113.06 | |
| Payroll Taxes | 4,892.92 | |
| Unemployment Tax | 378.70 | |
| Mimeographing | 1,530.95 | |
| Expense of Council and Committee Meetings | 1,361.02 | |
| Refunds—A. M. A. Dues | 37.50 | |
| —State Dues and Special Assessments | 56.00 | |
| Miscellaneous Expense | 2,261.78 | |
| Total Disbursements | | 38,661.52 |
| BALANCE—DECEMBER 31, 1959 | | $ 10,182.01 |

## MEDICAL JOURNAL FUND

### Statement of Receipts and Disbursements Calendar Year 1959

| | | |
|---|---|---|
| BALANCE—JANUARY 1, 1959 | | $ 9,347.74 |
| RECEIPTS | | |
| Advertising | $ 47,644.28 | |
| Emblems Sold | 127.00 | |
| Subscriptions | 271.72 | |
| Total Receipts | | 48,043.00 |
| | | 57,390.74 |
| DISBURSEMENTS | | |
| Printing | 30,795.36 | |
| Engraving | 482.45 | |
| Postage | 684.50 | |
| Salaries and Editing | 5,261.42 | |
| Travel | 280.45 | |
| Emblems Purchased | 150.00 | |
| Refund of Subscription | 3.50 | |
| Dues | 87.00 | |
| Clippings and Prints | 434.47 | |
| Telephone | 308.05 | |
| Miscellaneous | 250.07 | |
| Transferred to General Fund | 6,000.00 | |
| Transferred to Public Service Fund | 2,500.00 | |
| Total Disbursements | | 47,237.27 |
| BALANCE—DECEMBER 31, 1959 | | $ 10,153.47 |

## CONVENTION FUND

### Statement of Receipts and Disbursements Calendar Year 1959

| | | |
|---|---|---|
| BALANCE—JANUARY 1, 1959 | | $ 4,425.40 |
| RECEIPTS | | |
| Dues (Allocated to Convention Fund) | $ 4,023.00 | |
| Exhibit Space Sold | 9,215.00 | |
| Total Receipts | | 13,238.00 |
| | | 17,663.40 |
| DISBURSEMENTS | | |
| Supplies and Labor | 5,667.84 | |
| Travel | 926.18 | |
| Entertainment | 1,535.52 | |
| Telephone and Telegraph | 521.57 | |
| Postage | 20.00 | |
| Miscellaneous | 402.01 | |
| Total Disbursements | | 9,073.12 |
| BALANCE—DECEMBER 31, 1959 | | $ 8,590.28 |

## AMERICAN MEDICAL ASSOCIATION DUES

### Statement of Receipts and Disbursements Calendar Year 1959

| | |
|---|---|
| BALANCE DUE A. M. A.—JANUARY 1, 1959 | None |
| RECEIPTS | |
| Dues Collected for A. M. A. | $ 31,375.00 |
| | 31,375.00 |
| DISBURSEMENTS | |
| Dues Forwarded to A. M. A. | 31,375.00 |
| BALANCE DUE A. M. A.—DECEMBER 31, 1959 | $ None |


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## PUBLIC SERVICE FUND

### Statement of Receipts and Disbursements Calendar Year 1959

| | |
|---|---|
| BALANCE STATE ASSESSMENTS—JANUARY 1, 1959 | $ 622.97 |
| RECEIPTS | |
| Transferred from Medical Journal Fund | 2,500.00 |
| | 3,122.97 |
| DISBURSEMENTS | |
| Conference and General Expense | 570.97 |
| BALANCE STATE ASSESSMENTS—DECEMBER 31, 1959 | $ 2,552.00 |

## MEDICAL SCHOLARSHIP FUND

### Statement of Receipts and Disbursements Calendar Year 1959

| | |
|---|---|
| BALANCE—JANUARY 1, 1959 | $ 4,326.00 |
| RECEIPTS | |
| Assessments | 3,838.50 |
| | 8,164.50 |
| DISBURSEMENTS | |
| Scholarship Installments | 1,500.00 |
| BALANCE—DECEMBER 31, 1959 | $ 6,664.50 |

## SCHEDULE OF BONDS OWNED AS OF DECEMBER 31, 1959

| *Bond* | *Serial* | *Due Date* | *Maturity Value* |
|---|---|---|---|
| U. S Treasury 2½% | 27070L | 12-15-67/72 | $10,000.00 |
| U. S Treasury 2½% | 27846F | 12-15-67/72 | 10,000.00 |
| U. S Treasury 2½% | 70011A | 12-15-67/72 | 1,000.00 |
| U. S Treasury 2½% | 70012B | 12-15-67/72 | 1,000.00 |
| U. S Treasury 2½% (Sp. Fund) | 72331A | 12-15-67/72 | 1,000.00 |
| U. S Treasury 2½% | 19734D | 12-15-67/72 | 500.00 |
| U. S Treasury 2½% | 20707H | 12-15-67/72 | 500.00 |
| U. S Treasury 2½% | 20233E | 12-15-67/72 | 500.00 |
| U. S Treasury 2½% | 21421A | 12-15-67/72 | 500.00 |
| U. S Treasury 2½% | 21914D | 12-15-67/72 | 500.00 |
| U. S Treasury 2½% | 22646F | 12-15-67/72 | 500.00 |
| Series "J" | Q22297J | 1-1-1968 | 25.00 |
| Series "J" | Q22298J | 1-1-1968 | 25.00 |
| Total | | | $26,050.00 |

## COMPARATIVE SCHEDULE OF CASH AND BONDS AS OF DECEMBER 31, 1958 AND 1959

| | 12-31-58 | 12-31-59 | Increase (Decrease) |
|---|---|---|---|
| CASH | | | |
| General Fund | $13,326.92 | $10,182.01 | ($ 3,144.91) |
| Medical Journal Fund | 9,347.74 | 10,153.47 | 805.73 |
| Convention Fund | 4,425.40 | 8,590.28 | 4,164.88 |
| A. M. A. Dues | ..... | ..... | ..... |
| Public Service Fund | 622.97 | 2,552.00 | 1,929.03 |
| Medical Scholarship Fund | 4,326.00 | 6,664.50 | 2,338.50 |
| Total Cash | 32,049.03 | 38,142.26 | 6,093.23 |
| U. S. BONDS (at cost) | 25,818.68 | 25,818.68 | ..... |
| TOTAL CASH AND BONDS | $57,867.71 | $63,960.94 | $ 6,093.23 |

## New Reregistration Law in Maryland

The new physician reregistration law in Maryland which requires physicians to reregister triennially became effective June 1. All physicians who possess a license to practive medicine and surgery in Maryland, including those living out of that state who wish to keep their Maryland license alive are required to reregister with the Board of Medical Examiners.

Frank K. Morris, M. D., Board Secretary, requests that physicians in West Virginia who hold a Maryland license and who have not received reregistration application blanks by September 1 notify him and additional blanks will be mailed. His address is 1215 Cathedral Street, Baltimore 1, Maryland.


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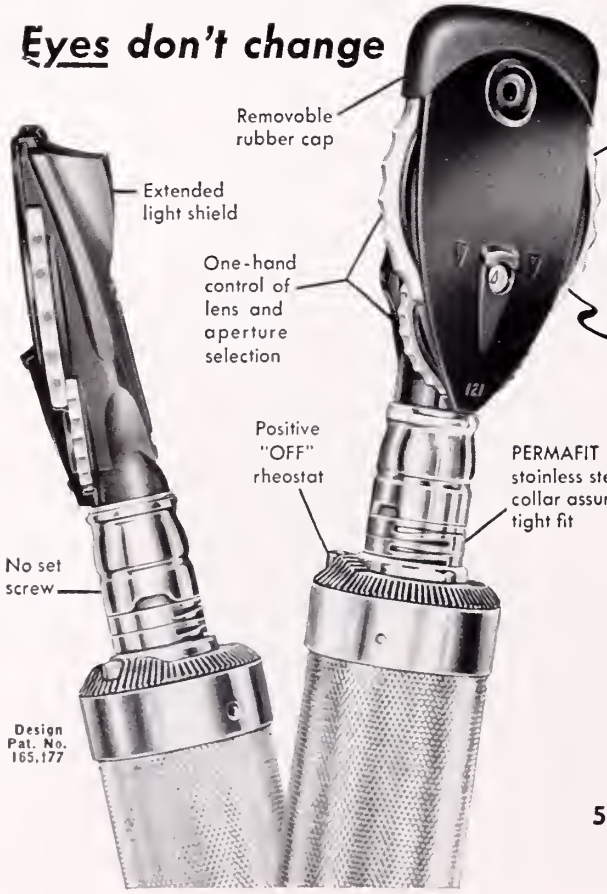


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# Obituaries

### RICHARD V. SHANKLIN, M. D.

Dr. Richard V. Shanklin, 86, of Bluefield died at his home in that city on May 20, 1960, following a brief illness.

Doctor Shanklin was born at Hunter's Spring, Monroe County, on November 4, 1873, son of the late John and Ellen (McNeer) Shanklin. He had his early education in the public schools of his home county and received his M. D. degree in 1900 from the Medical College of Ohio (now University of Cincinnati College of Medicine) and interned at the Good Samaritan Hospital in that city.

He served as chief physician for the United States Coal and Coke Company and succeeding companies at Gary from 1902 until 1946, when he retired and moved to Bluefield. While residing in McDowell County, he was a member of the McDowell County Medical Society and had served a term as president. When he moved to Bluefield, he transferred his membership to the Mercer County Medical Society.

At the time of his death, he was an honorary member of his local society, the West Virginia State Medical Association and the American Medical Association.

Besides his widow, the former Ann Landon Scott, he is survived by two sons, Dr. James R. Shanklin of Bluefield and Dr. Richard Shanklin, Jr., of Panama City, Florida.

* * * *

### SAMUEL H. BURTON, M. D.

Dr. Samuel H. Burton, 87, of Weston died at his home in that city on May 27, 1960, following a long illness.

Doctor Burton was born at Bradway, Rockingham County, Virginia, February 4, 1873, son of the late J. B. and Mary (Fauver) Burton. He had his academic education at Shenandoah Academy and received his M. D. degree from the Medical College of Virginia in 1897. He interned at Charity Hospital in New York City and had postgraduate work in ophthalmology and otolaryngology at New York Postgraduate School and at the Postgraduate School of the University of Pennsylvania.

He and his late brother, Dr. Marshall Burton, practiced their specialty of EENT at Parnassus, Virginia, for about 20 years and then located at Weston in 1917, where they operated an Eye, Ear, Nose and Throat Hospital until their retirement a few years ago.

He served as a Captain in the Medical Corps of the Army during World War I. He was an honorary member of the Central West Virginia Medical Society, the West Virginia State Medical Association, and the American Medical Association. He had served a term as president of his local society.

Doctor Burton is survived by a sister, Mrs. R. C. Keller of Staunton, Virginia.

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HUNTINGTON, WEST VIRGINIA

# County Societies

### BARBOUR-RANDOLPH-TUCKER

Mr. Jacob S. Hyer, attorney of Elkins, was the guest speaker before the regular monthly meeting of the B-R-T Medical Society, held at Blackwater Lodge, near Davis, on May 19, 1960. He discussed the relationship between physicians and attorneys and emphasized the importance of a pre-trial conference between the attorney and physician for the purpose of conserving time.

At the business meeting following the scientific program, the president was authorized to appoint a committee to study the matter of drawing blood from alcoholics for the purpose of alcohol determination. Dr. John H. Glynn was appointed chairman of the committee and the other members are Dr. Raymond W. Sass and Dr. A. C. Thompson.

Dr. John L. Rittmeyer was elected president of the Society to succeed Dr. Samuel C. Johnson. Other officers were elected as follows: First vice president, A. C. Thompson; second vice president, Guy H. Michael, Jr.; secretary, Charles L. Leonard (reelected); and treasurer, H. L. Jellinek (reelected).

The president, Doctor Johnson, presided at the meeting, which was attended by 23 members.—Charles L. Leonard, M. D., Secretary.

* * * *

### CABELL

Dr. Charles A. Doan of Columbus, head of the department of medicine and dean of the Ohio State University College of Medicine, was the guest speaker before the regular monthly dinner meeting of the Cabell County Medical Society, held in the Georgian Terrace at the Hotel Frederick in Huntington on May 12. His subject was "The Hypoplastic and Leukemic States—A Study in Common Denominators."

The speaker's main thesis was that hyperactivity and hypoactivity of the bone marrow often represent varying degrees of stimulation and depression by a wide variety of bacterial, viral, chemical, therapeutic and radioactive agents.

"Since hematological and bone marrow alterations appear long before clinical signs and symptoms," he said, "the physician should use the laboratory freely, so that he may detect pathological processes before they become irreversible."

Doctor Doan discussed in some detail the etiology, abnormal mechanisms, and treatment of the hypoplasias, the leukemias, and the myelophthisic and hypoplastic anemias. He pointed out that Gamma Globulin, also a product of the Reticulo-Endothelial System, may render the patient abnormally susceptible to secondary infections.

At the business meeting following the scientific session, Dr. Hassan Vaziri, orthopedic surgeon of Milton, was elected a member of the Society, and Dr. William F. Beckner of Huntington was elected to honorary membership.

Elected to associate membership were Drs. Walter H. Dearing, Seldon Rae Hoover, Eugene L. Walsh and Fred L. Patterson, Jr., all members of the staff of the Veterans Administration Hospital in Huntington.

The president, Dr. I. Ewen Taylor, presided at the meeting, which was attended by 57 members and guests.—W. L. Neal, M. D., Secretary.

* * * *

### CENTRAL WEST VIRGINIA

Dr. George P. Heffner of Charleston was the guest speaker before the regular monthly meeting of the Central West Virginia Medical Society held at Sutton on May 25, 1960. His subject was "Juvenile Diabetics."

The speaker stressed the value of Summer Camps for diabetic children. He said that there are two such camps located in West Virginia, Camp Kno-Koma and Camp Galahad. The Camps are open to all diabetic children, ages ten to fifteen.

In addition to regular Camp activities, Doctor Heffner said that the children are taught how to prepare diabetic diets and how to give insulin injections to themselves.

The Camps are supported by donations, but Doctor Heffner emphasized the fact that any eligible child may attend without charge.

At the business session following the scientific program it was announced that Dr. Donald Groves has been named to succeed Dr. William McClung as a member of the committee to examine minimum fee schedules.

The president, Dr. John E. Echols, presided at the meeting, arrangements for which were made by Dr. J. C. Eakle and Dr. B. M. Hutchinson.—Jane Freeman, M. D., Secretary.

* * * *

### HANCOCK

The annual dinner meeting of the Hancock County Medical Society and Auxiliary was held at the Williams Country Club in Weirton on Saturday evening, May 14, 1960.

Dr. George Naymick, the president, presided at the meeting and guests introduced included Dr. E. J. Van Liere of Morgantown, Dean of the WVU School of Medicine, Dr. J. C. Huffman of Buckhannon, President of the West Virginia State Medical Association, and Mr. Charles Lively of Charleston, Executive Secretary.

Dr. A. A. Yurko, president of the staff of Weirton General Hospital, introduced Dean Van Liere and paid professional tribute to him for his many years of service as Dean of the Medical School. Doctor Yurko then presented him with a gift from the members of the local medical society who are graduates of the Medical School at the University.

Honorable David T. Frew, Mayor of Weirton, also welcomed Doctor Van Liere and presented him with the Key to the city.

Doctor Van Liere will retire as Dean on July 1, but will continue to serve as professor of physiology on the University faculty.


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In his response, Doctor Van Liere discussed current and future developments of the University Medical School, the expansion of the student body, and the organization of the faculty to include highly trained and nationally recognized physicians.

Dr. Myer Bogarad, immediate past president of the West Virginia Chapter of the American Academy of General Practice, introduced Doctor Huffman and Mr. Lively. He commended them for their generous cooperation and efforts as guiding spirits of the State Medical Association.

In his formal address, Doctor Huffman discussed the medical care program in relation to the private physician and the state and federal governments. He emphasized the right of the individual to provide for his own medical needs as well as the privilege due the physician to administer medical care unhampered "by enforced restrictions and limitations" proved so often to be detrimental to the practice of medicine.

Mr. Lively discussed briefly the various medical care bills now pending in Congress, as well as proposed state legislation.

At the conclusion of the formal program, Doctor Naymick presented gifts from the Society to both Doctor Huffman and Mr. Lively.

Dr. E. M. Clubb, Jr. was chairman of the committee on arrangements, and he was assisted by Doctor Naymick and Dr. Ray S. Greco.—Arthur Phillips, M. D., Secretary.

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**Eye, Ear, Nose and Throat:**
E. Lloyd Jones, M. D.
T. J. Pavlick, M. D.

**Orthopedic Surgery:**
C. B. Buffington, M. D.

**Thoracic Surgery:**
Daniel W. Dickinson, M. D.

**Obstetrics and Gynecology:**
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.

**Urology:**
Richard D. Gill, M. D.

**Neurological Surgery:**
James S. Rogers, M. D.
Frank M. Hudson, M. D.

**Internal Medicine:**
William M. Sheppe, M. D.
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

**Neurology and Psychiatry:**
Albert L. Wanner, M. D.

**Roentgenology:**
William K. Kalbfleisch, M. D.

**Clinical Laboratories:**
Barbara Karrer, M. T.

**Technologists:**
Electrocardiology:
Joan Vensel, R. N.
Electroencephalography:
JoAnn Hastings
Roentgenology:
Evelyn Forester, R. T.

**Business Administration:**
John H. Clark, Manager
Lester L. Cline, Ass't. Bus. Mgr.

### MARION

Dr. S. L. Stillings of Mannington was elected president of the Marion County Medical Society at the regular monthly meeting held at the Fairmont Hotel on May 31, 1960.

Dr. F. W. Mallamo was elected vice president, and Dr. George T. Evans and Dr. C. S. Lawson, Jr., reelected secretary and treasurer, respectively.—George T. Evans, M. D., Secretary.

* * * *

### MASON

At a meeting of the Mason County Medical Society held on May 5, 1960, the following resolution was unanimously adopted:

"Resolved, That the members of the Mason County Medical Society are aware of the significance of the Forand Bill and its bearing upon the health of the people.

"We firmly believe that this bill would result in poorer, not better, health care for the people of this country.

"We firmly believe that the Forand Bill is socialized medicine, although, temporarily limited in scope.

"The Forand Bill would restrict the aged in their choice of hospital and physician.

"We also firmly believe that the Forand Bill would severely handicap the professional relationship between the doctor and his patient, which is actually the basis of effective health care.

"We are opposed to the increase in the already crushing load of taxation.

"We strongly favor a means of private enterprise, through relatively low-cost insurance to take care of people in need.

"Be It Resolved, That the Mason County Medical Society go on record as being opposed to the Forand Bill."—Dan B. Glassman, M. D., Secretary.

* * * *

### McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held at the residence of Dr. and Mrs. A. J. Villani in Welch on Wednesday, May 11.

The Society reaffirmed its opposition to the Forand


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A. KYLE BUSH, M. D.

**Gynecology and Obstetrics:**
RAYMOND W. CRONLUND, M. D.

**Internal Medicine:**
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

**Pediatrics:**
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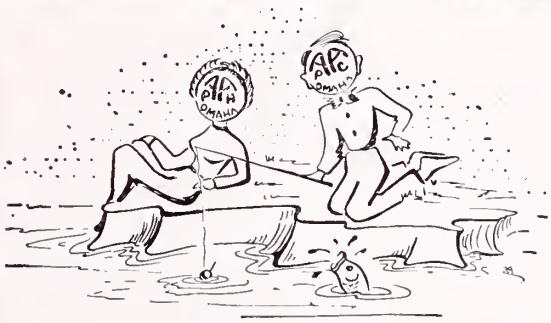

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Bill, and a resolution on the subject, unanimously adopted, was ordered mailed to both U. S. Senators and the Representatives in Congress from West Virginia. Members were asked to write letters to the Congressional delegation, expressing opposition to this type of pending legislation.

Films concerning the "Etiology and Localization of Arteriosclerosis," "Management of Hand Injuries," and "The Surgical Management of Dystonia in Children" were shown by Dr. Dante Castrodale, chairman of the program committee.

The president, Dr. Guy E. Irvin, presided at the meeting which was attended by twenty members and guests.—George L. Fischer, M. D., Secretary.

* * * *

### MERCER

Dr. David W. Wayne was the guest speaker before the Mercer County Medical Society at the meeting held on May 16 at the University Club in Bluefield. His subject was "The Gravity of the Problem of Mental Health."

At the business meeting following the scientific program, Dr. Robert W. Neilson and Dr. John J. Bryan were elected to membership in the Society.

A report was received from the committee on a Home for the Chronically Ill and Aged and it was agreed that the president is to appoint a new committee to assist in the establishment in Mercer County of a home for the Care of the Chronically Ill and Aged.

Dr. Henry Warden, the president, presided at the meeting, which was attended by 34 members and two guests. The speaker was introduced by Dr. L. J. Pace.—John J. Mahood, M. D., Secretary.

* * * *

### RALEIGH

Dr. Eberhard Trams of Bethesda, Maryland, was the guest speaker at the regular monthly meeting of the Raleigh County Medical Society which was held at the El Chico Cafe in Beckley on May 19.

Doctor Trams, who is currently engaged in cancer research at the National Institutes of Health, presented an interesting paper on "Cancer Chemotherapy."

It was announced that Dr. Charles I. Allen, Jr., of Beckley, plans to move in July to Laurens, South Carolina.

Dr. F. Vivan Lilly, the president, presided at the dinner meeting which was preceded by a social hour.—Preston C. Davis, M. D., Secretary.


Peter P. Ladewig, M. D. Willis D. Garrard, M. D.

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## OFFICERS OF COMPONENT SOCIETIES

| Society | President | | Secretary | | Meetings |
|---|---|---|---|---|---|
| Barbour-Randolph-Tucker | Samuel C. Johnson | Parsons | Chorles L. Leonard | Elkins | 3rd Thurs. |
| Boone | James M. Scott | Madison | H. H. Howell | Modison | 2nd Wed. |
| Brooke | James E. Wise | Follansbee | H. L. Hegner | Wellsburg | ---------- |
| Cabell | I. Ewen Taylor | Huntington | W. L. Neal | Huntington | 2nd Thurs. |
| Central West Virginia | John E. Echols | Richwood | Jone Freeman | Buckhannon | As Scheduled |
| Eastern Panhandle | George F. Pugh | Martinsburg | F. A. Homilton, Jr. | Mortinsburg | Quorterly |
| Fayette | Thomas C. Sims | Longocre | Marvin Kirsh | Montgomery | 1st Wed. |
| Greenbrier Valley | E. T. Cobb | Ronceverte | Jomes Homilton | Marlinton | 2nd Wed. |
| Hancock | George Naymick | Weirton | Arthur Phillips | Weirton | 2nd Tues. |
| Harrison | Richard V. Lynch, Jr. | Clarksburg | Andrew J. Weover | Clorksburg | 1st Thurs. |
| Konawha | Milton J. Lilly | Charleston | A. B. Curry Ellison | Chorleston | 2nd Tues. |
| Logon | Roy M. Kessel | Logan | Luke Combs | Man | 2nd Wed. |
| Marion | S. L. Stillings | Monnington | G. Thomas Evans | Fairmont | Last Tues. |
| Marshall | H. B. Ashworth | Moundsville | J. W. Myers | Moundsville | Semi-Ann. |
| Mason | C. Leonard Brown | Pt. Pleasant | Don Glassmon | Pt. Pleasant | ---------- |
| McDowell | Guy E. Irvin | Welch | George L. Fischer | Welch | 2nd Wed. |
| Mercer | W. E. Copenhover | Bluefield | John J. Mahood | Bluefield | 3rd Mon. |
| Mingo | Fronk J. Burian | Williamson | Russell A. Salton | Williomson | 2nd Thurs. |
| Monongalia | David Z. Morgon | Morgantown | C. A. Logue | Morgontown | 1st Tues. |
| Ohio | S. S. Bobes | Wheeling | H. G. Dickie | Wheeling | 4th Tues. |
| Parkersburg Acodemy | Jack J. Stark | Belpre, Ohio | Robert M. Biddle | Parkersburg | 1st Thurs. |
| Potomac Valley | P. R. Wilson | Piedmont | H. L. Eye | Fronklin | 2nd Wed. |
| Preston | John F. Lehman | Kingwood | C. Y. Moser | Kingwood | 4th Thurs. |
| Raleigh | F. Vivan Lilly | Beckley | Preston C. Davis | Beckley | 3rd Thurs. |
| Summers | Jack D. Woodrum | Hinton | A. W. Holmes | Hinton | 3rd Wed. |
| Toylor | R. D. Stout | Grafton | Herbert N. Shanes | Grafton | Last Thurs. |
| Wetzel | Lemoyne Coffield | New Martinsville | C. P. Watson, Jr. | New Martinsville | Monthly |
| Wyoming | E. M. Wilkinson | Pineville | R. E. Newman | Mullens | Quarterly |

# Woman's Auxiliary

to the

## WEST VIRGINIA STATE MEDICAL ASSOCIATION

*President:* Mrs. Robert R. Pittman, Marlinton
*President Elect:* Mrs. Clark K. Sleeth, Morgantown
*First Vice President:* Mrs. V. L. Dyer, Petersburg
*Second Vice President:* Mrs. Myer Bogarad, Weirton
*Third Vice President:* Mrs. John F. Morris, Huntington
*Fourth Vice President:* Mrs. P. A. Tuckwiller, Charleston
*Treasurer:* Mrs. George A. Curry, Morgantown
*Recording Secretary:* Mrs. Rupert W. Powell, Fairmont
*Corresponding Secretary:* Mrs. James W. Hamilton, Marlinton
*Parliamentarian:* Mrs. J. Preston Lilly, Charleston

### FAYETTE

Mrs. Thomas C. Sims of Longacre was installed as president of the Woman's Auxiliary to the Fayette County Medical Society at the May meeting which was held at the home of Dr. and Mrs. Raymond A. Updike in Montgomery.

Other new officers are as follows: Mrs. Joe N. Jarrett of Oak Hill, vice president; Mrs. J. B. Thompson of Oak Hill, secretary; and Mrs. Ivan H. Bush, Jr., of Oak Hill, treasurer.

Mrs. Pat A. Tuckwiller of Charleston, southern regional director of the Woman's Auxiliary to the West Virginia State Medical Association, installed the officers.

Mesdames Clint W. Stallard and T. Kerr Laird were in charge of arrangements for the meeting.—Mrs. Joe N. Jarrett, Correspondent.

* * * *

### GREENBRIER

A luncheon meeting of the Woman's Auxiliary to the Greenbrier Valley Medical Society was held May 17, at the home of Mrs. J. G. Leech in Quinwood.

Mrs. Eugene Morhous of White Sulphur Springs, chairman of the Auxiliary Convention Committee, outlined the program which will be presented at the annual meeting at The Greenbrier in August.

The Auxiliary voted unanimously to put the publication, "Today's Health," in the high schools of Greenbrier and Pocahontas counties, effective with the issue for September.

Miss Carol Shinaberry of Pocahontas County was named as the Auxiliary's recipient of the nursing scholarship award.

The record by Sam Levenson, "But Seriously Folks," was played and discussed by Mrs. George Lemon.—Mrs. Ruth Martin, Correspondent.

* * * *

### McDOWELL

Mrs. Hendrick A. Bracey was elected president of the Woman's Auxiliary to the McDowell County Medical Society at the May meeting which was held at the home of Dr. and Mrs. E. D. Gibson in Iaeger.

Other officers are as follows: Mrs. Odis Glover, president elect; Mrs. A. A. Carr, first vice president; Mrs. George L. Fischer, second vice president; Mrs. J. Hunter Smith, secretary; and Mrs. John S. Cook, treasurer.

Mrs. Dante Castrodale, retiring president, presided at the meeting. The chairman of several committees presented reports and the Auxiliary contributed $250 to the McDowell County Crippled Children's Association.

Mrs. Gibson and Mrs. Carl T. Clark were in charge of arrangements for the meeting.—Mrs. J. Hunter Smith, Correspondent.

* * * *

### OHIO

Mrs. Robert T. Bandi of Wheeling was installed as president of the Woman's Auxiliary to the Ohio County Medical Society at the Annual Installation Luncheon held on May 24 at Wilson Lodge in Oglebay Park, Wheeling. Other new officers are as follows:

President elect, Mrs. Andrew K. Butler; vice president, Mrs. George M. Kellas; recording secretary, Mrs. J. Speed Rogers; corresponding secretary, Mrs. Harry Weeks; and treasurer, Mrs. Herbert G. Dickie.

Mrs. George M. Kellas was named program chairman for the new year.

Mrs. R. R. Pittman of Marlinton, president of the State Auxiliary, was the honor guest at the luncheon. Mrs. George R. Clarke was chairman of the hostesses. She was assisted by Mesdames A. J. Niehaus, C. H. Hiles, J. K. Stewart, H. R. Sauder, and J. P. Griffith. —Mrs. Robert S. Robbins, Publicity Chairman.

* * * *

### PARKERSBURG

Mrs. Charles H. Barnett was installed as president of the Woman's Auxiliary to the Parkersburg Academy of Medicine at a luncheon meeting held at the Hotel Chancellor on May 16. Other new officers are as follows:

Mrs. George Gevas, president elect; Mrs. David B. Thornburgh, first vice president; Mrs. Charles W. Thacker, second vice president; Mrs. George E. McCarty, recording secretary; Mrs. Donald R. Lantz, corresponding secretary; and Mrs. Lawrence R. Leeson, treasurer.

Mrs. Charles L. Goodhand, first vice president of the Woman's Auxiliary to the American Medical Association, installed the new officers, and Mrs. S. William Goff presented a silver tray to Mrs. Edward Shupala, the retiring president.

The guest speaker was Mr. Leonard E. Read, president of the Foundation for Economic Education, Inc., Irvington-on-Hudson, New York. His subject was "Essence of Americanism."

Hostesses for the meeting were Mrs. George E. McCarty, chairman, and Mesdames Ralph H. Boice, Richard B. Sheridan, A. R. Sidell, and James L. Wade. —Mrs. George Gevas, Correspondent.

---

Throw away all ambition beyond that of doing the day's work well.—Sir William Osler.

# Book Reviews

**COMMUNICABLE AND INFECTIOUS DISEASES—By Franklin H. Top, M. D., Professor and Head, Department of Hygiene and Preventive Medicine, State University of Iowa, Iowa City. Pp. 812, with illustrations. Fourth Edition. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Mo. 1960. Price $20.00.**

The 4th Edition of this standard text is ably presented and edited by the author and 21 collaborators.

The widening field of infectious diseases is thoroughly covered. The new chapers on the acute respiratory infections and viral diseases are unusually interesting. Many of the less common diseases have been de-emphasized so that the book is actually smaller than the previous editions.

The first section of 175 pages is a general review of Infection Immunity and the control of communicable diseases. Diseases are classified throughout the book by portal of entry.

As stated in the 1st edition preface, the book is intended to be a handy reference for all physicians who see or treat communicable diseases.

In the first and second chapters in section 2, there are excellent accounts of the diseases, Coccidioidomycosis and Histoplasmosis. The account provides as thorough an understanding as present literature permits. There are other fungus diseases of the lungs of increasing incidence and importance and one wonders why there is no mention, for instance, of Blastomycosis or Moniliasis.

All the diseases are described under the usual text book headings and include definition, history, epidemiology, and detailed clinical manifestations and complications.

* * * *

## Books Received

**EDEMA—Mechanisms and Management** — A Hahnemann Symposium on Salt and Water Retention. Edited by John H. Moyer, M. D., Professor and Chairman of the Department of Medicine, and Morton Fuchs, M. D., Assistant Professor of Medicine, Hahnemann Medical College and Hospital, Philadelphia. Pp. 833, with illustrations. Philadelphia & London: W. B. Saunders and Company. 1960. Price $15.00.


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| Central West Virginia | Mrs. Elden H. Pertz | Weston | Mrs. George E. Farrell | Webster Springs |
| Eastern Panhandle | Mrs. Curtis G. Power | Martinsburg | Mrs. Curtis G. Power | Martinsburg |
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| Hancock | Mrs. George Rigas | Weirton | Mrs. Roy Conrad | Weirton |
| Harrison | Mrs. James A. Thompson | Clarksburg | Mrs. Paul E. Gordon | Clarksburg |
| Kanawha | Mrs. George Miyakawa | Charleston | Mrs. W. W. Currence | South Charleston |
| Logan | Mrs. Ray M. Kessel | Logan | Mrs. Henry Bobroff | Man |
| Marion | Mrs. O. M. Goodwin | Fairmont | Mrs. William T. Lawson | Fairmont |
| McDowell | Mrs. H. A. Bracy | Welch | Mrs. J. H. Smith | Welch |
| Mercer | Mrs. Gordon L. Todd, Jr. | Princeton | Mrs. Robert S. Gatherum | Bluefield |
| Mingo | Mrs. W. W. Scott | Williamson | Mrs. Robert Tchou | Williamson |
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| Taylor | Mrs. Paul P. Warden | Grafton | Mrs. H. N. Shanes | Grafton |
| Wood | Mrs. Charles H. Barnett | Parkersburg | Mrs. Donald R. Lantz | Parkersburg |
| Wyoming | Mrs. Mario Cardenas | Mullens | Mrs. C. T. Upchurch | Oceana |

# Correspondence

BOX 443, BEREA COLLEGE
Berea, Kentucky

May 17, 1960

Charles Lively, Executive Secretary
West Virginia State Medical Association
Box 1031
Charleston, West Virginia

Dear Mr. Lively:

Your letter of May 13 in which you informed me officially of the action of your Medical Scholarships Committee in selecting me for the 1960 Medical Scholarship award was deeply appreciated. It was good to see the written words.

Commencement at Berea will be held on June 5; therefore, the Medical Journal may be sent to my college address if it is released that early in the month. My home address is Box 53, Gilbert, West Virginia. I shall keep you posted concerning my summer address.

Give Bill my regards, also. I enjoyed our brief acquaintance. I had to feel humble in the presence of the many fine fellows in Charleston.

With great appreciation, I am.

Sincerely yours,
Signed) Glenn Buchanan

---

WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE
Morgantown

June 7, 1960

Mr. Charles Lively, Executive Secretary
West Virginia State Medical Association
Charleston, West Virginia

Dear Mr. Lively:

Again, I want to thank you and the members of the West Virginia State Medical Association for the financial assistance afforded me on my recent trip to the Student American Medical Association Convention in Los Angeles.

Both my wife and I enjoyed the privilege of representing the West Virginia Chapter of SAMA and Auxiliary at the Convention. This was our first trip to the west coast and one we thoroughly enjoyed.

The Convention was held at the Statler-Hilton Hotel from May 4th to the 8th. There were 1200 delegates registered from the various medical schools throughout the country. I met many of the delegates in the Chapter Clinics, and, through the informal exchange of ideas, was able to bring back information which will be helpful in planning a more active program for next year.

One project we have in mind is an annual "High School Day." This would involve setting aside one day each year for a tour of the Medical School and Teaching Hospital by high school students from over the state. Through this program we hope to attract more of the qualified students to the field of Medicine.

One of the high points of the Convention was a panel discussion on the pros and cons of Forand-type legislation. The SAMA House of Delegates later supported a resolution recognizing a need for the solution of the problems of medical care for the aged, but favoring a solution that would maintain the present high standards of medical care. It was not felt that Forand-type legislation would accomplish this goal.

I hope that it will be possible for you to attend some of our local meetings next year. Your ideas and suggestions would be most welcome.

Sincerely,
(Signed) Charles L. Ladwig, Jr.


LIFE STORY

The leading site of cancer today is the colon and rectum. In 1958, 58,000 new cases were diagnosed.

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*eferences:* 1. Lichtman, A. L.: *Kentucky Acad. Gen. ract. J.* 4:28, Oct., 1958. 2. Lichtman, A. L.: Scientific hibit, Internat. Coll. Surgeons, Miami Beach, Fla., Jan. 7, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 127, April. 1960.

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### No Change in Feelings as Age Advances

It is an unfortunate thing that many people, doctors, nurses, social workers and even clergy, have very little understanding of what it feels like to be old. This is the reason for the defective approaches we so often find. We are all familiar with the antipathy which looks on old age as dirty and repellent, and the aged themselves as better dead. The patronage which fundamentally despises age and which talks down to it, is an equally sterile approach, unproductive of good because of the lack of identification between the parties concerned.

What is so easy to forget is that our feeling about ourselves do not fundamentally change as age advances, even though mentation may slow and memory begin to fail. We still retain our personalities and are hurt if they are ignored. It is then no wonder that people who have throughout their lives grouped themselves into clubs and societies according to their interests and achievements should object to be classified into undifferentiated old people. It is in the neglect of the personality, that we who are doctors, nurses and social workers most surely fail.

Security of tenure in the home is, at least, in some degree under our control if we will pay attention to the essential services which support home-care. Home-Helps, "Meals on Wheels," day-visitors and night-attendants all play their part in providing security. Residential hostels which provide sick rooms to avoid unnecessary admission to hospitals all do their duty, but these efforts will be ineffective if family doctor, nurse and home-matron have omitted to learn the art of nursing the elderly-frail. Many old people who are "problems" where they are living, would not be so if only someone would learn the technique of handling them.—Thomas N. Rudd, M. D., in Journal, American Geriatrics Society.

### Breaking Age Barriers

Aging of the human body has been a subject of intriguing interest to philosophers and scientists since time began. How do we grow old? How old is old? When does one cease being young? These are common expressions and represent the interest of thoughtful people in quiet moments when they search for orientation and perspective.

Medical science has made substantial contributions in lengthening the life span by the discovery and elaboration of procedures that have minimized the ravages of many diseases. Sanitation, prophylaxis, better understanding of nutrition, more accurate methods for the study of disease, and earlier diagnosis of conditions such as tuberculosis, the anemias and cancer have resulted in the more efficient treatment of common maladies. All this sums up to the saving of many lives.

More people are living into the mature and later years of life than at any previous time in the history of mankind. Statistically, since the number of older people is increasing, new problems of social, cultural, economic, medical, and spiritual significance arise.—Edward L. Bortz, M. D., in Medical Annals of the District of Columbia.


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SEPTEMBER
1960

Vol. 56 No. 9

The
WEST VIRGINIA
Medical Journal

Official Organ of the West Virginia State Medical Assaciatian

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.

Member 1960

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1. Eisen, H. N., and Tobachnick, M.: Protein Metabolism, M. Clin. North America 39:863 (May) 1955. 2. Jamison, R. M.: General Nutritive Deficiency, Virginia M. Month. 83:67 (Feb.) 1956. 3. Goldforb, A. F.; Napp, E. E.; Stone, M. L.; Zuckermon, M. B., and Simon, J.: The Anabolic Effects of Norethandrolone, a 19-Nortestosterone Derivative, Obst. & Gynec. 11:454 (April) 1958. 4. Batson, R.: Investigator's Report, Feb. 11, 1956. 5. Weston, R. E.; Isaacs, M. C.; Rosenblum, R.; Gibbons, D. M., and Grossman, J.: Metabolic Effects of an Anabolic Steroid, 17-Alpha-Ethyl-17-Hydroxy-Norandrostenone, in Human Subjects, J. Clin. Invest. 35:744 (June) 1956. 6. Brown, C. H.: The Treatment of Acute and Chronic Ulcerative Colitis, Am. Pract. & Digest Treat. 9:405 (March) 1958.

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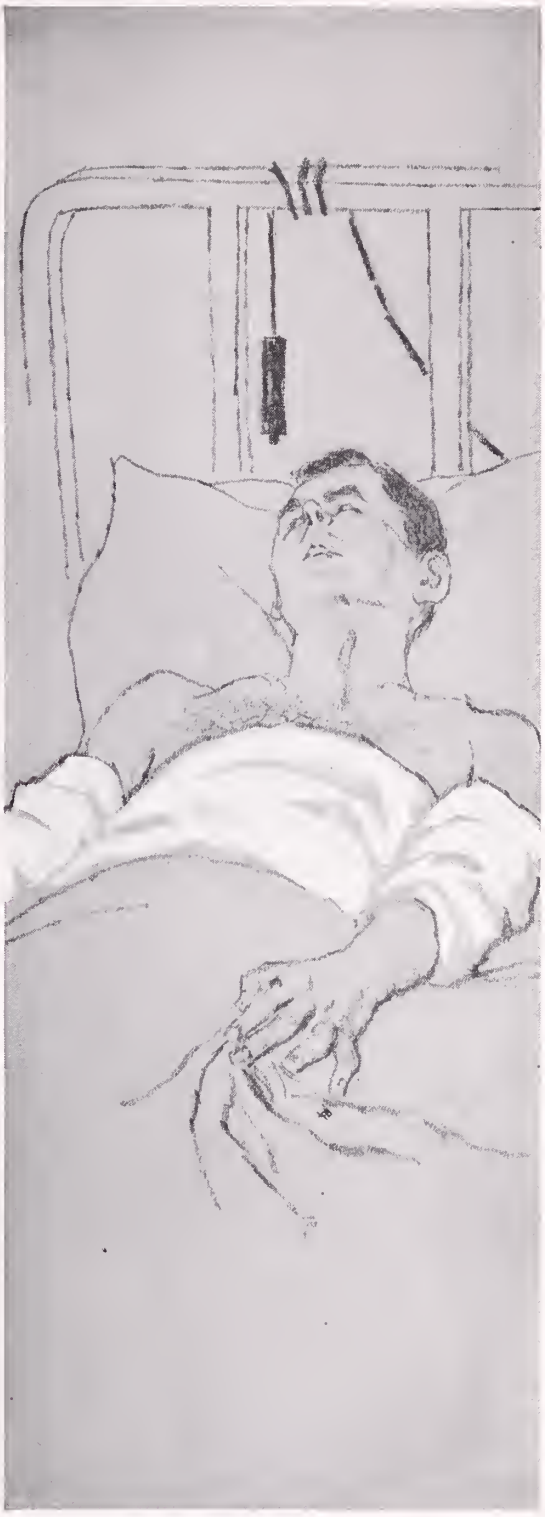

# WVU Medical Center
# —News—

• Compiled from moteriol furnished by John B. Horley, M. D., Assistant Professor of Medicine ond Public Informotion Officer at the WVU Medicol Center in Morgontown, W. Vo.

DR. Walter H. Gerwig of Clarksburg has been appointed Clinical Associate Professor of Surgery at the West Virginia University School of Medicine. The appointment was announced last month by President Elvis J. Stahr, Jr.

Doctor Gerwig is Head of the Department of Surgery at the Veterans Administration Hospital in Clarksburg, a position in which he will continue to serve.

A native of Parkersburg, Doctor Gerwig was graduated from West Virginia University in 1931 and received his M. D. degree from the University of Maryland School of Medicine in 1935. He interned and served a residency in surgery at University Hospital in Baltimore, 1935-41.

During World War II he served six years with the Medical Corps of the United States Army and was released in 1946 with the rank of Lieutenant Colonel.

Prior to moving to Clarksburg in 1959, Doctor Gerwig served as Associate Professor of Surgery at the George Washington University School of Medicine. He also was a consulting surgeon to the Walter Reed Hospital in Washington.

He is certified by the American Board of Surgery and is a member of the American College of Surgeons, the American Surgical Association, the Harrison County Medical Society, West Virginia State Medical Association and American Medical Association.

### Dr. Zimmermann Receives Research Grant

President Elvis J. Stahr, Jr., announced recently that the Department of Surgery at the WVU School of Medicine was awarded a $104,648 research grant by the National Institutes of Health, U. S. Department of Health, Education and Welfare.

Dr. Bernard Zimmermann, Professor and Chairman of the Department of Surgery said the grant will be used over a three-and-one-half year period to support a study of "The Regulation of Electrolyte Balance in Surgery." He said the major objective is the advancement of knowledge of the effects of major surgery on body chemistry.

Assisting in the project will be Dr. Walter H. Moran, senior resident and instructor in surgery. Drs. Zimmermann and Moran were associated in similar investigations at the University of Minnesota Medical School prior to joining the faculty of the School of Medicine.

### School of Nursing Accepts 27 Students

The following 27 students have been accepted for enrollment in the first entering class at the West Virginia University School of Nursing:

Emily Anderson, Parkersburg; Barbara Archer and Penelope Ingram, Buckhannon; Nancy Boxell, Elkins; Judith Deegan, Culloden; Jane Douglas, Charleston; Judy Dove, Peterstown; Janet Eskew, Bridgeport; Elizabeth Gibson, Sutton; Jane Gibson, Weston; Patsy Hesen, Elizabeth Kuykendall and Katherine Martin, Morgantown; and Christina Kochenderfer, Parsons.

Beverly Huemme, Roberta Rinehart and Susan Wagner, Fairmont; Linda Lemasters, Clendenin; Carol Neel, Uffington; Lila Parsons, Moorefield; Janet Salvati, Monongah; Mary Pnakovich, Valley Bend; Imogene Tomlin, Shenandoah Junction; Mary Varney, Williamson; Edith Wilson, Lewisburg; Marti Workman, Wheeling; and Barbara Wright, Fairview.

### USPHS Pharmacology Training Grant

A five-year grant totaling $128,700 was recently awarded to the University by the United States Public Health Service. The grant, which is the largest of its kind ever received by the University, will be used to assist in the training of graduate students in pharmacology.

Dr. Daniel T. Watts, professor of pharmacology, said the grant will help students who are working toward their master's or doctor's degrees in pharmacology, as well as medical and dental students doing special work in the field.

He said approximately half of the annual allotment under the grant will be used for stipends to trainees. The remainder will pay the salary of a member of the pharmacology faculty and buy supplies and equipment to be used in research.

### Hospital Dedication on October 8

Plans are being made for the formal dedication of the Teaching Hospital on October 8. The dedication will climax nine years of planning which began with the appointment of a Medical Center building committee in the fall of 1951.

Eugene L. Staples, director of the Teaching Hospital, has been named chairman of a committee to plan dedication events. Other members are Dr. Edward J. Van Liere, Dr. John M. Slack, chairman of the building committee, Dr. Clark K. Sleeth, Mr. Cletis Pride and Dr. Kenneth E. Penrod.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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# The Month in Washington

DEMOCRATS and Republicans are campaigning on opposing planks on the issue of health care for the aged. The Democratic party advocates the Social Security approach; the Republican party favors federal aid in the field, but outside the Social Security system.

### The GOP Plank

The GOP plank pledged:

"Development of a health program that will provide the aged needing it, on a sound fiscal basis and through a contributory system, protection against burdensome cost of health care. Such a program should:

"—Provide the beneficiaries with the option of purchasing private health insurance—a vital distinction between our approach and Democratic proposals in that it would encourage commercial carriers and voluntary insurance organizations to continue their efforts to develop sound coverage plans for the senior population.

"—Protect the personal relationship of patient and physician.

"—Include state participation."

### The Key Democratic Plank

The key paragraph of the Democratic plank stated:

"The most practicable way to provide health protection for older people is to use the contributory machinery of the Social Security system for insurance covering hospital bills and other high cost medical services. For those relatively few of our older people who have never been eligible for Social Security coverage, we shall provide corresponding benefits by appropriations from the general revenue."

Charles H. Percy, Chairman of the GOP Platform Committee, stated that the reference to a "contributory system" in the Republican plank did not mean a Social Security tax.

### Candidates Pledge Support

Presidential and Vice Presidential candidates of both parties went into the election campaigns pledged to support the health-care-for-the-aged planks adopted by their respective conventions. Vice President Richard M. Nixon, the GOP Presidential nominee, already was on record as unalterably opposed to any program of national compulsory health insurance. The long-established position of Sen. John F. Kennedy of Massachusetts, the Democratic Presidential candidate, has been "that only by use of the Social Security system can we have true health insurance."

• **From the Washington Office of the American Medical Association.**

### The AMA Position

Speaking for the American Medical Association, Dr. Edward R. Annis of Miami, Florida, appeared before the platform-drafting committee of the Democratic convention at Los Angeles, and Dr. Leonard W. Larson, AMA President-elect, before the Republican policy group at Chicago.

The AMA spokesmen warned both parties that a program following the Social Security approach "would be unpredictably costly; it would unnecessarily cover millions of people; it would substitute service benefits for cash benefits; it would lead to poorer—not better—quality of medical care; it would overcrowd our hospitals; it would lead to the decline, if not the demise, of private health insurance; and it would interfere dangerously with the doctor-patient relationship, which is the solid foundation upon which effective medicine must be based."

Doctor Annis also urged support of the House-approved Mills plan to provide health care for the needy aged who need help with the federal government and the states sharing the costs outside the Social Security mechanism.

### AMA Sponsors Ads in Dailies

In an advertisement run in some large daily newspapers in mid-August, the AMA outlined its reasons for supporting the Mills plan. The ad said, in part:

"The AMA believes our nation, as well as its senior citizens, will best be served by a locally administered health aid program designed *To Help Those Who Need Help.*

". . . We are equally sincere in our opposition to legislative measures that approach the problem on a shotgun basis, with the idea of increasing repeatedly the Social Security tax in order to finance health benefits for *Everyone* who is covered by the Old Age, Survivors and Disability Insurance program, regardless of their need.

"There are many serious hazards in using the Social Security approach to finance medical and hospital care for our older citizens. When government starts telling the doctor how to practice medicine; telling the nurses how to nurse; telling the hospital how to handle its patients, the quality of medical care is sure to decline."

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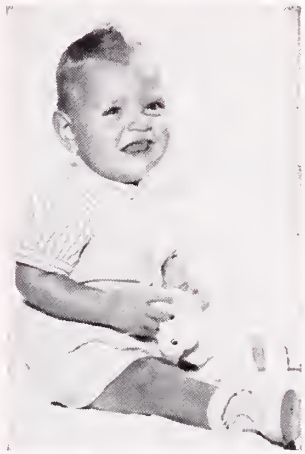

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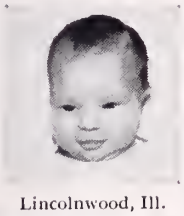

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# Obituaries

### SYLVESTER P. ALLEN, M. D.

Dr. Sylvester P. Allen, 88, of Webster Springs, died at a hospital in that city on July 28, 1960.

Doctor Allen was born at Elroy, West Virginia, April 20, 1872. He was graduated from Central Normal School in Kentucky in 1900 and received his M. D. degree from the Kentucky School of Medicine in 1901. He located at Webster Springs where he engaged in general practice continuously until his retirement in 1958.

He was an honorary member of the Central West Virginia Medical Society, the West Virginia State Medical Association and the American Medical Association, and had served a term as president of his local society.

Doctor Allen also served a term as clerk of the county court of Webster County.

Besides his widow, he is survived by a sister, Mrs. Dave Hefner of Dorset, Ohio.

* * * *

### DWIGHT P. CRUIKSHANK, M. D.

Dr. Dwight P. Cruikshank, 85, of Lumberport, died suddenly at his home in that city on August 10, 1960. He had been in failing health for several weeks.

Doctor Cruikshank was born in Spring Valley, New York, December 23, 1874, son of the late John Clark and Nellie Rachel (Harrick) Cruikshank. He had his early education in the Spring Valley public schools and received his M. D. degree from the College of Physicians and Surgeons of Baltimore in 1902. He served his internship at Mercy Hospital in that city.

He located at Montana Mines (Marion County) in 1902 and moved to Pennsboro in 1905. He located at Lumberport in 1908, where he remained in active practice until shortly before his death.

He was always interested in the civic affairs of his community and served at various times as mayor, city recorder and health officer of Lumberport.

He was an honorary member of the Harrison County Medical Society, the West Virginia State Medical Association and the American Medical Association.

He was married in 1910 to Coral Sharp of Pennsboro, who died in 1953. One son, Hamilton Clark Cruikshank, preceded his father in death, and he is survived by another son, Dr. Dwight P. Cruikshank, III, a practicing physician in Parkersburg.

* * * *

### CHARLES L. PARKS, M. D.

Dr. Charles L. Parks, 81, of Fairmont, died on July 21, 1960, at a hospital in that city, following an extended illness.

Doctor Parks was born at Shilo, Tyler County, West Virginia, son of the late Dr. and Mrs. Lloyd L. Parks. He was graduated from West Virginia Wesleyan College in 1900 and received his M. D. degree from the University of Maryland in 1904. He interned at St. Agnes Hospital in Baltimore, and located at Atwood, Tyler County, where he engaged in practice there and at Middlebourne.

After having postgraduate work in Baltimore, he located at Fairmont for the practice of his specialty of internal medicine. Doctor Parks continued in active practice in Fairmont until his retirement in 1955.

He was an honorary member of the Marion County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Besides his widow, the former Mona Langfitt of Morgansville, he is survived by a daughter, Mrs. William Alan McLane, Jr., of Fairmont; two sons, Seigle W. Parks, M. D., of that city, and Carlton L. Parks of Chatham, N. J.; and a sister, Mrs. William Ballantine of Pine Grove.

* * * *

### S. D. H. WISE, M. D.

Dr. S. D. H. Wise, 92, of Parkersburg, who since 1958 has been residing with a daughter in Washington, D. C., died July 21, 1960.

Doctor Wise was born at Big Tree, Pennsylvania, and had his academic education at Ohio Wesleyan College, Delaware, Ohio. He received his M. D. degree from the Kentucky School of Medicine in 1897.

He located at Parkersburg immediately after his graduation from medical school and continued in active practice there until his retirement in 1958.

He was an honorary member of the Academy of Medicine of Parkersburg, the West Virginia State Medical Association and the American Medical Association. He had served as secretary-treasurer, and president of his local society.

Besides his widow, he is survived by a daughter, Mrs. Paul S. Murphy of Washington, D. C.

## MLB to Meet Oct. 3

The fall meeting of the Medical Licensing Board will be held at the new State Office Building in Charleston on October 3, 1960, for the purpose of examining applicants for licensure by reciprocity to practice in this state.

Serenity emerges from four Faiths: Faith in Deity, Faith in Humanity, Faith in Life, and Faith in Self . . . the last of which is not the least.—The Oracles.


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# County Societies

### CENTRAL WEST VIRGINIA

Dr. Donald R. Roberts of Elkins was the guest speaker at a meeting of the Central West Virginia Medical Society which was held at Camp Caesar on July 28. His subject was "Where Are We Going In Medicine."

Dr. John E. Echols of Richwood, the president, presided at the business meeting and Drs. J. M. Cofer, Jack W. Hunter and George B. Edmiston were in charge of arrangements.

Dr. R. L. Chamberlain of Buckhannon, Chairman of the Committee in charge of arrangements for a postgraduate meeting to be sponsored by the Society, announced that the meeting will be held in September. He said speakers on the program will include members of the faculty at the West Virginia University School of Medicine.

Dr. Earl L. Fisher of Gassaway, Chairman of the Rural Health Committee of the West Virginia State Medical Association, announced that the program has been completed for the 13th Annual Rural Health Conference that will be held at Jackson's Mill on October 6.—Jane Freeman, M.D., Secretary.

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Things turn up for him who digs.—Anon.

## Dr. R. P. Hagerman Named Member Of Important SREB Council

Dr. R. P. Hagerman, director of the West Virginia Department of Mental Health, has been appointed by Governor Cecil H. Underwood as the West Virginia member of the Southern Regional Education Board's Council on Mental Health Training and Research. The Council is composed of an appointee by the governor of each of the sixteen participating states, together with eight members appointed by the SREB. The Council advises the Board concerning policy and projects in connection with its mental health training and research program.

The Board's mental health program is designed to assist Southern states in obtaining well-trained mental health personnel and in bringing about a more effective exchange of knowledge and ideas among the mental health groups.

The Southern Regional Education Board was directed by the Southern Governors' Conference in 1954 to establish the mental health program, with financial support from the participating states, West Virginia's contribution being $8,000 per annum.

The Board was established in 1949 under interstate compact now ratified by legislative action in Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.


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# Book Reviews

**SCIENCE AND MEDICINE OF EXERCISE AND SPORTS—Edited by Warren R. Johnson, Ed.D., Professor of Health Education and Physical Education, College of Physical Education, Recreation and Health, University of Maryland. Pp. 740. Harper & Brothers, 49 East 33rd Street, New York 16, N. Y. 1960. Price $12.00.**

This is a technical symposium designed for professional people and graduate students, to which 42 leading researchers in physiology, physical education, psychology and medicine have contributed chapters. Bringing together in one volume a statement of our present knowledge of various aspects of the field of exercise and sports, the book encourages further research by indicating the limitations of our knowledge and the directions in which research is needed.

Top authorities in their respective fields, the contributors include David Bruce Dill, formerly director of the famous Harvard Fatigue Laboratory, Lucien Brouha, Ernst Gellhorn, Edward F. Adolph, Charles H. McCloy, Bruno Balke, Jean Mayer, Nathan W. Shock and Emma McCloy Layman. Doctor Layman is chief psychologist at Children's Hospital, Washington, D. C.

Dr. Edward J. Van Liere, Dean, West Virginia University School of Medicine, and Dr. J. Clifford Stickney, Professor of Physiology, are among the contributors to this book. They are the authors of Chapter 12 which deals with "The Effects of Exercise Upon the Function of the Gastrointestinal Tract."

For the benefit of nonspecialists in the various areas, each chapter begins with a simply stated summary of its contents.

The editor, Warren R. Johnson, has been conducting research in the field of exercise and sports for many years, dealing primarily with the psychological and emotional aspects.

This volume is an excellent compendium for the serious student of the effect of exercise and sports, be he coach, trainer, physician or physiologist.—John B. Harley, M. D.

* * * *

**MEDICAL CARE OF THE ADOLESCENT—By J. Roswell Gallagher, M. D., Chief, Adolescent Unit, The Children's Hospital Medical Center, Boston, and Lecturer on Pediatrics, Harvard Medical School. Pp. 369, with several illustrations. Appleton-Century-Crofts, Inc., 35 West 32nd Street, New York 1, N. Y. 1960. Price $10.00.**

Dr. J. Roswell Gallagher is too well known as an expert on the medical care of the adolescent to need his qualifications discussed here. He has compiled a book which may become quite popular as an introduction to the medical care of the adolescent.

After a few chapters in which he discusses general aspects of the adolescent, Doctor Gallagher attacks particular problems which are likely to be troublesome both to the patient and physician. Most of the later

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chapters are arranged in a way that one would not ordinarily encounter in a textbook of medicine, since they vary from such subjects as diabetes to undescended testes, and acne to athletic injuries, each of which is discussed succinctly and embraced within a moderate number of pages.

Certain of Doctor Gallagher's themes recur throughout the book. For instance, the adolescent's interest in himself which must be recognized by the physician if he is to establish satisfactory rapport, and the need for the physician to be sympathetic and attempt to evaluate the patient as a whole rather than as a disease. His repetition is a good method of teaching and is not boring. Knowing where to place the emphasis is one of the subtle things which make medicine an art, and this book should help physicians do that properly.

In many of the chapters, the author provides a set of rules of thumb for the management of particular conditions which may often be seen in the office of the general practitioner, pediatrician or internist. Many of these conditions relate to other fields of medicine but should be handled more easily with such knowledge as Doctor Gallagher imparts. The availability of a handy reference for conditions not rare but infrequent is a reassuring addition to an office library.

One of the more valuable portions of this book is the section devoted to the evaluation of fitness and developmental status. It provides a number of references and tables to evaluate both maturation and fitness, and these may prove of considerable value to the physician who is called upon to provide some tangible basis for the evaluation of athletic or work capacity. Related to this is an excellent discussion of cardiac problems, including innocent murmurs of adolescence.

There is an important allowance for the psychologic aspect of adolescence; nevertheless, the organic ones are not slighted and the reader gets the feeling from reading the book that the statements are made by someone who has been over the ground and who knows what he is talking about. The solutions are usually more practical than theoretical.

There are a few places where the smoothness and quality of the writing are not consistently good; however, one may forgive this in evaluating the book as a whole.

The book appears to be well indexed and has a large number of references. It is recommended as a guide to those physicians who wish to have help finding paths through the maze of adolescent complaints.—Donald M. Burke, M. D.

* * * *

**CURRENT SURGICAL MANAGEMENT II. Edited by John H. Mulholland, M. D., Editor-in-Chief, New York University College of Medicine; Edwin H. Ellison, M. D., Marquette University School of Medicine; and Stanley R. Friesen, M. D., University of Kansas Medical Center. Contributions by fifty authorities. Pp. 348, with illustrations. Philadelphia and London: W. B. Saunders Company. 1960. Price $8.00.**

This books deals with controversial problems in a brief but very helpful manner. It is a supplement to Volume I which was published three years ago. While this volume covers new subjects, it also presents a

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limited number of recently formulated concepts on problems covered in Volume I.

The book is edited by Drs. Mulholland, Ellison and Friesen who have chosen the subject material and selected the writers. The editors explain the problem and the reason for the controversy in brief and clear introductory statements at the beginning of each new "chapter."

Fifty recognized authorities have contributed to the volume. They have written on such problems as duodenal ulcer, polyps of the colon, esophageal hiatal hernia, carcinoma of the head of the pancreas, choledocholithiasis, repair of common duct stricture, sphincterotomy, pilonidal sinus, carcinoma of breast, intestinal intubation, vascular diseases of the lower extremities, acute renal failure, prolapse of the rectum and colon preparation for operation.

The placing of alternate viewpoints by recognized authorities side by side emphasizes once again that surgery is still an inexact science. Because of this, there are ever changing concepts as new facts are brought to light and as thoughtful men study problems more carefully. This volume points to the need for constant study by surgeons and for the maintenance of open minds.

The book is recommended to all who are practitioners or students of general surgery. It should help prevent its readers from developing unwarranted dogmatism without substituting an unhealthy skepticism.—Hu C. Myers, M. D.

* * * *

**OFFICE DIAGNOSIS—By Paul Williamson, M. D. Pp. 470, with illustrations. Philadelphia and London: W. B. Saunders Company. 1960. Price $12.50.**

This is a first edition of a unique presentation. In this day of assembly line diagnosis, it is refreshing to be reminded and informed that most of our medical problems can be diagnosed through observation and clinical acumen, with a minimal amount of office laboratory assistance.

The book includes 70 pages devoted to a description of non-specific symptoms such as headache, fever, syncope, weight loss, coma, etc. The remainder of the book describes symptoms in relation to systems or body areas. The symptom is described, necessary physical examination is indicated, and special examination, pitfalls, consultations and complications are stated.

Some of the studies are highly elementary. Much of it has been once known, but now forgotten. The emphasis is on history and examination. The point is made that, in many diseases, negative laboratory reports furnish no diagnostic assistance.

Many physicians will find this a handy, helpful book to have in a convenient place. The emphasis is on the ordinary ailment. There is no attempt to include all possible causes of a particular complaint. The author states, "Medical teaching and philosophy of today constantly emphasizes the complex and difficult, while 99 per cent of human ills are of simple and direct nature."

**MEDICAL RESEARCH AND THE DEATH PENALTY—By Jack Kevorkian, M. D. Pp. 75. Vantage Press, Inc., 120 West 31st Street, New York 1, N. Y. 1960. Price $2.50.**

This book is not a one course but a full-course dinner for anyone interested in human welfare in all its phases.

The author offers a very provocative and sensible solution to the problem of lethal punishment for crimes against society. He submits a strong argument against our present medieval modes of punishment, and offers in their place a humane method of what we call "payment of a criminal's debt to society." He urges the substitution of scientific medical research, under humane conditions, for the ancient "eye for an eye" custom.

The different phases of the subject are presented in the manner of informal debate between an antagonist and protagonist of the general problem, the laws affecting the subject, the criminal, the physician, and the public, with a brief review of the general outlook on future results of his suggested treatment of the problem.

I shall not go into detail. Read it yourself without prejudical bias, and you are in for an interesting time. —James S. Klumpp, M. D.

* * * *

**THE LIST METHOD OF PSYCHOTHERAPY—By Elizabeth Sher, et al, with an introduction by Jacob S. List. Pp. 258. Philosophical Library, 15 E. 40th Street, New York City. 1960. Price $7.50.**

The Jacob S. List method of psychotherapy is as unique in many respects as the book which describes it. This is a book written by therapists who have been trained in the List method and the only direct contribution by List is his introduction to the volume. The book begins as a readable volume but bogs down into a series of quotes, statistics and tables which take away much of its effectiveness. The six authors, having six separate styles of writing, also make for difficulty of understanding at times.

In spite of these obstacles there are ideas worthy of consideration, idcas that are new in some respects and time proved in others. The essence of the List method is the substitution of "a program for a problem." He encourages self analysis, uses counter transference frequently in the very treatment process and feels that the central core of his method is the use of warmth,


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love and affection in the treatment process. The emotion of love, of sympathy and of understanding, not only in treatment but in the waiting room and in the social life of his patients, is emphasized. They give lip service to flexibility in the List method but in the final analysis flexibility does not seem to be practiced as much as other methods.

There is emphasis on preventive psychiatry, the use of research and a blend of the art and science of psychotherapy. List proposes maximum use of the patient's resources and describes his therapy more as an educative process than anything else.

Most psychotherapy is limited to treatment in the office. Not so the List method. He encourages patients to get together after their sessions in the office, encourages them to enter into social activities with one another outside the office setting, encourages them to discuss their problems together as they wait in the outside office for their therapy session.

Each therapist utilizing the List method is a former patient in which he has recognized what he considers qualifications for therapy. They are taught under his direction, are supervised rather closely for a while and then allowed to treat on their own. No therapist possesses a medical or psychology degree. In fact most of them are educators by training.

In essence, the List method of psychotherapy is one man's idea and his attempt to transpose this idea into practice. There are those who have been benefited by it and those, it is assumed, who have not. In any event there are few people who could not be benefited by maximum use of the qualities List sees in a therapist, that is love with courage, strength with understanding and empathy with sympathy.—David M. Wayne, M. D., and William T. Luzader, M. S. W.

* * * *

**INDUSTRIAL PULMONARY DISEASES—By E. J. King, M.A., D.Sc., F. R. I. C., and C. M. Fletcher, C.B.E., M. D. (Cantab.), F. R. C. P., Postgraduate Medical School of London. Pp. 273, with illustrations. Little, Brown and Company, Boston 6, Massachusetts. 1960. Price $8.50.**

This little book is based on a symposium of the Postgraduate Medical School of London in September, 1957 and March, 1958. It consists of a series of 21 lectures by 23 contributors. The lectures are concerned with Industrial Pulmonary Diseases in Great Britain.

The various chapters are written well and read well. The lectures do presuppose some knowledge of Industrial Pulmonary Disease on the part of the reader. The system of classification of the pneumoconioses is that recommended by the International Labour Organization.

There are 45 pages devoted to measurement of normal and abnormal lung function. Many of these procedures can only be undertaken in laboratories which have costly equipment and specially trained personnel.

The chapters that describe the nature of the various radiopaque dusts in the lungs are interesting to their particular industry and point to the special hazard and its prevention or correction.


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The chapter on Chronic Bronchitis should be informative to all physicians. The high prevalence of Chronic Bronchitis in Great Britain has been a mystery to American Medicine, but the rapidly increasing incidence of this serious disease in the United States indicates the need for further knowledge for our physicians.

The titles of the various chapters are related, but the book is not a complete text on Industrial Pulmonary Diseases. It will be helpful to physicians who are concerned with the rapid increase of Chronic Pulmonary disease.

A glossary explaining the many abbreviations would be helpful.

* * * *

## Books Received

**YOUR CHILD'S CARE**—By Harry R. Litchfield, M. D., Director, Department of Pediatrics and Baby Care Clinics, Brooklyn Women's Hospital, and Leon H. Dembo, M. D., Assistant Clinical Professor of Pediatrics, Western Reserve University School of Medicine. Pp. 257. Doubleday & Company, Inc., 575 Madison Avenue, N. Y. 22, N. Y. 1960. Price $3.95.

* * * *

**FRENCH'S INDEX OF DIFFERENTIAL DIAGNOSIS**—Edited by Arthur H. Douthwaite, M. D., F. R. C. P., Senior Physician, Guy's Hospital, and Honorary Physician, Westminster Hospital, and All Saints' Hospital for Genito-urinary Diseases, with twenty contributors. Pp. 958, with 774 illustrations, 216 in color. Eighth Edition. The Williams and Wilkins Company, Baltimore 2, Md., exclusive U. S. Agents. 1960. Price $24.

**PRACTICAL CLINICAL MANAGEMENT OF ELECTROLYTE DISORDERS**—By William J. Grace, M. D., Director of Medicine, The St. Vincent's Hospital of the City of New York; Professor of Clinical Medicine, New York University School of Medicine; formerly, Associate Professor of Medicine, Cornell University Medical College. Pp. 132, with illustrations. Appleton-Century-Crofts, Inc., 35 West 32nd Street, New York 1, N. Y. 1960. Price $4.95.

* * * *

**RUDOLPH MATAS**—By Isidore Cohn, M. D., with Hermann B. Deutsch. Pp. 431. Doubleday & Company, Inc., 575 Madison Avenue, New York 22, New York. 1960. Price $5.95.

* * * *

**PARAPLEGIA: A HEAD, A HEART, AND TWO BIG WHEELS**—By Jules Saltman. Pp. 28, with five drawings by Dick Shelton. Public Affairs Committee, Inc., 22 East 38th Street, New York 16, N. Y. 1960. Price 25 cents.


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# Correspondence

**VOCATIONAL REHABILITATION DIVISION**
**State Board of Vocational Education**
**Charleston 5, West Virginia**

June 30, 1960

Dr. J. C. Huffman, President
W. Va. State Medical Association
Buckhannon, West Virginia

Dear Dr. Huffman:

Since early April we have been trying to employ a physician to provide medical services to the clients of the West Virginia Rehabilitation Center, Institute, West Virginia. Thus far we have had little success. Perhaps you would be good enough to make our requirements known at meetings or through official publications of the Society.

As you know, we are operating a 175 bed, vocationally oriented, multiple disability Rehabilitation Center at Institute, West Virginia, as an instrument for preparing the physically and mentally handicaped for employment. We are providing comprehensive services: vocational evaluation, vocational training, and therapy, including instruction in the use of appliances. The therapy program and appliance fitting is done under the guidance of Dr. Harold H. Kuhn. In addition to this, we are desperately in need of the services of a physician, possibly an internist, for the management of the general run of illness that 175 people living as a group fall heir too, as well as the management of the special problems of the severely disabled—decubiti, urological problems, diabetic routines, special diets, etc. Our present budget allows for employment of a physician on a half time basis. The time allowed can be increased as the work load demands.

Your active support and that of all members of the Society is hopefully solicited in the effort to provide better services to West Virginia's disabled citizens in West Virginia.

Sincerely,

(Signed) F. Ray Power,
Director

## Health a Harmonizer

Man's most basic instinct, as we know, is the preservation of life and health. In countries where life expectancy is half our own, where each year a third of the babies die during the first year of life, one of the greatest aids to American international relations is medicine. It is medicine which promises to these people freedom from constant suffering, greater productivity and longer life. Two thousand years ago, Galen said, "Health is a sort of harmony." In one area of the world after another, we are seeing that health is not only a harmony but a harmonizer.—U. S. Senator John Sparkman in Journal, Med. Assn., State of Alabama.

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|---|---|---|---|---|---|
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| Boone | James M. Scott | Madison | H. H. Howell | Madison | 2nd Wed. |
| Brooke | James E. Wise | Follansbee | H. L. Hegner | Wellsburg | |
| Cabell | I. Ewen Taylor | Huntington | W. L. Neal | Huntington | 2nd Thurs. |
| Central West Virginia | John E. Echols | Richwood | Jane Freeman | Buckhannon | As Scheduled |
| Eastern Panhandle | George F. Pugh | Martinsburg | F. A. Hamilton, Jr. | Martinsburg | Quarterly |
| Fayette | Thomas C. Sims | Longacre | Marvin Kirsh | Montgomery | 1st Wed. |
| Greenbrier Valley | E. T. Cobb | Ronceverte | James Hamilton | Marlinton | 2nd Wed. |
| Hancock | George Naymick | Weirton | Arthur Phillips | Weirton | 2nd Tues |
| Harrison | Richard V. Lynch, Jr. | Clarksburg | Andrew J. Weaver | Clarksburg | 1st Thurs. |
| Kanawha | Milton J. Lilly | Charleston | A. B. Curry Ellison | Charleston | 2nd Tues. |
| Logan | Ray M. Kessel | Logan | Luke Combs | Man | 2nd Wed. |
| Marion | S. L. Stillings | Mannington | G. Thomas Evans | Fairmont | Last Tues. |
| Marshall | H. B. Ashworth | Moundsville | J. W. Myers | Moundsville | Semi-Ann. |
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| McDowell | Guy E. Irvin | Welch | George L. Fischer | Welch | 2nd Wed. |
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| Potomac Valley | P. R. Wilson | Piedmont | H. L. Eye | Franklin | 2nd Wed. |
| Preston | John F. Lehman | Kingwood | C. Y. Moser | Kingwood | 4th Thurs. |
| Raleigh | F. Vivan Lilly | Beckley | Preston C. Davis | Beckley | 3rd Thurs. |
| Summers | Jack D. Woodrum | Hinton | A. W. Holmes | Hinton | 3rd Wed. |
| Taylor | R. D. Stout | Grafton | Herbert N. Shanes | Grafton | Last Thurs. |
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*ITERATURE SUPPLYING DETAILS OF DOSAGE AND ADMINISTRATION AVAILABLE ON REQUEST.*

*1) Abraham, W., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 956, p. 132. (2) Crawley, J. W.:* M. Clin. North America 42:317 *(March) 1958. (3) Bray, P. F.:* Pediatrics 23:151, *1959.*

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Vol. 56 No. 10

# The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Assaciatian

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publicotion Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publicotion. The author or communicant shall be held entirely responsible.

Entered as second-class matter Jonuory 1, 1926, at the post office at Charleston, West Virginia, under the oct of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rotes furnished on request. Address oll communications to Business Manager, West Virginia Medicol Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.

Member 1960

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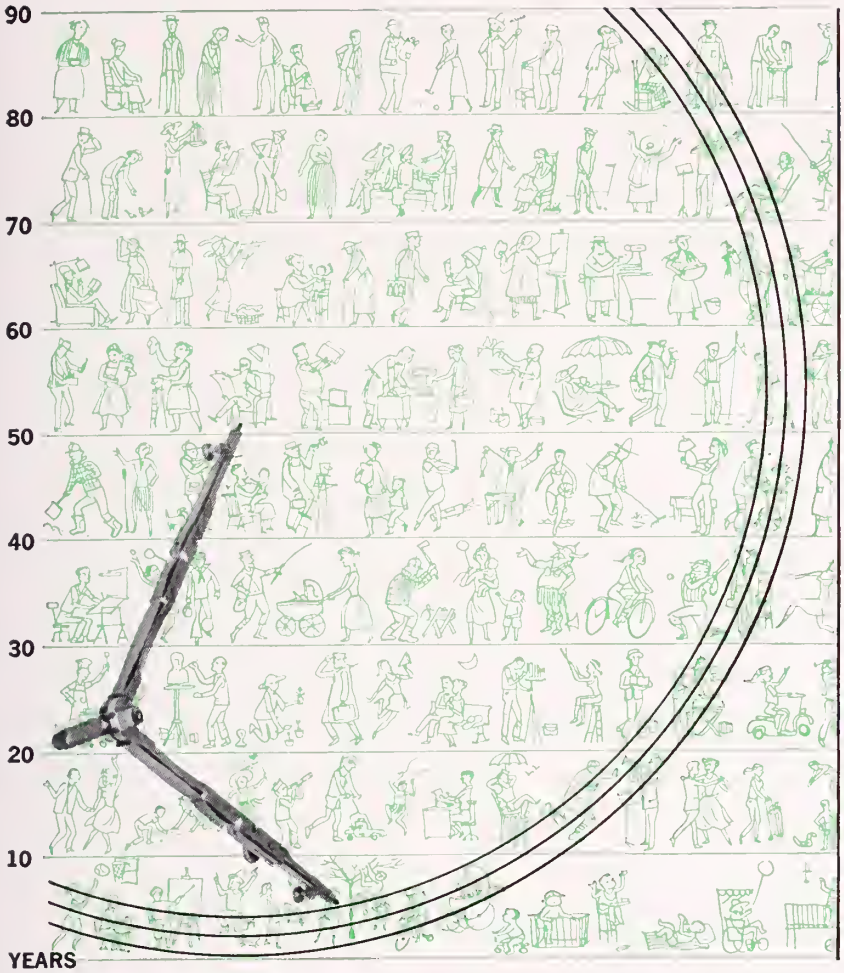


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# Obituaries

### GEORGE W. JOHNSON, M. D.

Dr. George W. Johnson, 81, of Beckley died at a hospital in that city on September 20, 1960, following a long illness.

Doctor Johnson was born in Jonesville, Virginia, on October 17, 1878. He graduated from Bethany College in 1903 and received his M. D. degree from the Medical College of Virginia in 1907. He served his internship at Beckley Hospital and then had postgraduate work at Johns Hopkins.

He located at McAlpin in Raleigh County where he engaged in general practice until his retirement in January, 1959, when he moved to Beckley.

In 1959, he was presented with a 50-year plaque by the Raleigh County Medical Society.

He was an honorary member of the Raleigh County Medical Society, the West Virginia State Medical Association and the American Medical Association. He had served a term as president of his local Society.

Doctor Johnson also served for six years as a member of the Raleigh County Board of Education.

Besides his widow, he is survived by a daughter, Mrs. Eleanor Kahn of Daytona Beach, Florida; and two sons, Edmund C., of Charleston and Lewis A., of Pittsburgh, Pennsylvania.


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### HARRY THEODORE SCHIEFELBEIN, M. D.

Dr. Harry Theodore Schiefelbein, 63, of Welch, died at his home in that city on August 17, 1960.

Doctor Schiefelbein was born at New Lisbon, West Virginia, July 19, 1897. He received his M. D. degree from the Medical College of Virginia in 1923, and was licensed to practice medicine in West Virginia in 1924.

He had postgraduate work in EENT at Bellevue Hospital in New York City, after which he located at Eckman. He moved to Welch in 1933 where he engaged in the practice of his specialty at the Stevens Clinic Hospital.

He was a member of the McDowell County Medical Society, the West Virginia State Medical Association and the American Medical Association, and had served as president and secretary of his local society.

Besides his widow, he is survived by two daughters.

* * * *

### CLAUDE B. SMITH, M. D.

Dr. Claude B. Smith, 53, of Charleston, died at a hospital in that city on September 15, 1960, following a long illness. Death was attributed to cancer.

Doctor Smith was born at Ohio Pyle, Pennsylvania, December 1, 1906, son of Brackett Ayers and Lilly (Woodward) Smith. He attended public schools in Bluefield and was graduated from the Narrows, Virginia, high school. He received his B. S. degree from the University of Virginia in 1926, and his M. D. degree from the University of Virginia School of Medicine in 1930.

He interned at Church Home and Infirmary, Baltimore, 1930-31, and served a residency at Johns Hopkins, 1932-33.

Doctor Smith practiced for a few months in Virginia where he was a member of the Albermarle County Medical Society. He located at Charleston in 1933 for the practice of his specialty of orthopedic surgery. He was licensed in West Virginia that same year.

Doctor Smith served as Captain in the AUS during World War II and was released from the service in 1945 with the rank of Major. Immediately following World War II, he served as chairman of the State Medical Association's Veterans Affairs Committee.

He was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association. He was also a member of the American Academy of Orthopedic Surgeons, the American College of Surgeons, American Board of Orthopedic Surgeons and the Southeast Surgical Congress.

Besides his widow, he is survived by two daughters, Mrs. Rachel Dickhut of West Dupere, Wisconsin, and Betty Ann Smith of Charleston; two sons, Thomas and Michael of Charleston; and a brother, Lee Smith of Uniontown, Pennsylvania.

---

To be seventy years young is sometimes far more cheerful and hopeful than to be forty years old.—Oliver Wendell Holmes.

# County Societies

### EASTERN PANHANDLE

Dr. Jules F. Langlet of Charles Town was the guest speaker before the regular monthly dinner meeting of the Eastern Panhandle Medical Society, held at the Town House Restaurant in Harpers Ferry on September 14. His subject was "Femoral Arteriography." He presented several case histories, using color slides and x-ray films.

At the conclusion of his address, there was an open discussion by several members.—F. A. Hamilton, M. D., Secretary.

* * * *

### PARKERSBURG ACADEMY

Dr. John W. Hope of Philadelphia was the guest speaker at the regular monthly meeting of the Parkersburg Academy of Medicine which was held at the American Legion Home on September 1.

Doctor Hope, professor of clinical radiology at the University of Pennsylvania School of Medicine, discussed "Malignancy in Infancy and Childhood." He outlined the value of certain types of x-ray in the correct diagnosis of abdominal cancer in children.

Dr. Jack J. Stark, the president, presided at the meeting and the guest speaker was introduced by Dr. Rex Dauphin.—Robert M. Biddle, M. D., Secretary.

### The Hairs on Your Head

Hair is nourished from below, hence it can't be nourished from atop. It can't be changed to permanently wavy or permanently straight, either. This is because round hair shafts grow straight while oval shafts grow curly, and the shape of the shaft is determined below the top layer of skin.

If you are average, your hair grows about an inch every six weeks. If you are a man, the hairs on your head are almost all different from the ones that were there six months ago. You constantly create new skin, new bone and new blood cells, too. Fact is, don't be surprised if you wake up tomorrow feeling like a new person!—Journal, Kansas Medical Society.


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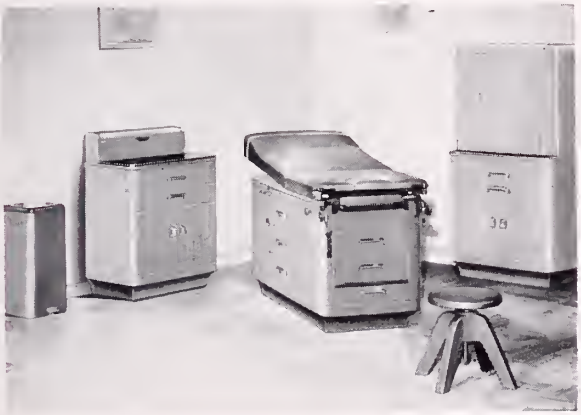

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*Corresponding Secretary:* Mrs. C. A. Smith, Morgantown
*Parliamentarian:* Mrs. Claude R. Davisson, Weston

### HARRISON

The annual membership tea of the Woman's Auxiliary to the Harrison County Medical Society was held at the home of Dr. and Mrs. Herman Fischer in Bridgeport on Thursday afternoon, September 8.

The hostess, Mrs. Fischer, who is president of the Auxiliary, met members and guests as they arrived and introduced them to the following officers who were in the receiving line: Mrs. Clark K. Sleeth of Morgantown, president of the State Auxiliary; Mrs. Vernon L. Dyer of Petersburg, president elect; Mrs. George A. Curry of Morgantown, second vice president; and Mrs. Andrew J. Weaver, treasurer.

Mrs. Sleeth presented an interesting address on the state theme, "Promoting an Awareness of the Auxiliary." She urged local auxiliaries to use health subjects as their service programs.

Mrs. Joseph Gilman, social chairman was in charge of arrangements for the tea.

The meeting was attended by 37 members and guests. —Mrs. Paul E. Gordon, Correspondent.

### Proposed Constitutional Amendment

The following amendment to the Constitution of the West Virginia State Medical Association, offered at the 93rd Annual Meeting at The Greenbrier in White Sulphur Springs, August 25-27, 1960, by James P. McMullen, M. D., of Wellsburg, Chairman of the Committee on Constitution and By-Laws, will be acted upon finally by the House of Delegates at the 94th Annual Meeting in 1961:

**Article IX**

Sec. 3—Amend the Section in line one by deleting the word "President."

(The effect of the amendment would be to eliminate the necessity of electing a president at each annual meeting. Section 2 of Chapter VI of the By-Laws provides that the president elect shall be installed as president as the final order of business at the last session of the House of Delegates at each annual meeting).


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# Book Reviews

**RUDOLPH MATAS, A Biography of One of the Great Pioneers in Surgery—By Isiodore Cohn, M. D., with Herman B. Deutsch. Pp. 431. Doubleday and Company, Inc., 575 Madison Avenue, New York 22, New York. 1960. Price $5.95.**

This is a fascinating story of the lives of father and son, the former being a restless rover, the latter one of the great pioneers of modern medicine.

The father of Rudolph Matas was born in Spain, married at 19, and then emigrated to Louisiana to make his fortune. He studied pharmacy and medicine but for a long time did very little practice. The Civil War had started and he became a trader of everything from cattle to rum. He frequently ran the blockades of both the northern and southern forces and collaborated with the hated General Butler. In these exploits he was enormously successful and soon was worth several hundred thousand dollars.

Because of his exploits, he found it increasingly uncomfortable in New Orleans. He went back to Spain and from there journeyed to Paris where he studied ophthalmology. Following his graduate studies he moved to Barcelona to practice, but was not successful in his new specialty. He speculated in railway stocks and lost all the money he had amassed in the United States.

He returned to New Orleans, made another fortune, but found himself classed with the carpetbaggers and, therefore, unwanted. Because of this, he moved to Texas, then California, and finally to Arizona where he practiced many years and finally died. He sent his son Rudolph back to New Orleans for his education.

In New Orleans, Rudolph Matas entered the Medical College of the University of Louisiana. He studied and worked hard and received the highest honors in his class. He also received a coveted residency in Charity Hospital. While a student he was appointed as clerk of the Yellow Fever Commission of the National Board of Health which studied Yellow Fever in Havana for several months. The most significant contributions of the Commission were the blood studies and photomicrographs made by Rudolph Matas. These formed the foundation on which the cause and prevention of yellow fever was to be built.

After graduation he practiced general medicine and surgery and later became professor of surgery at Tulane University. At the age of 21, he became editor of the *New Orleans Medical and Surgical Journal.* He made significant contributions to surgery in a study of appendicitis, in developing local anesthesia, and in perfecting intestinal sutures. His major contribution, however, was made in the development of vascular surgery. He is said to have fathered the entire concept of latter-day vascular surgery.

The book is a factual account of the lives of these two doctors but mostly, Dr. Rudolph Matas. The story is not only interesting, but inspiring, as it tells of the trials and tribulations of one of the pioneers who contributed so much to our understanding of basic prob-

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lems of modern surgery. The book is recommended to anyone who is connected with medicine in any way and also to laymen who are interested in understanding some of the problems of the development of medicine and its allied professions.—Hu C. Myers, M. D.

* * * *

## Books Received

**CARDIAC EMERGENCIES.**—By Harold D. Levine, M. D. Senior Associate in Medicine, Peter Bent Brigham Hospital, Boston, and Assistant Clinical Professor of Medicine, Harvard Medical School. Pp. 381, with numerous illustrations. Landsberger Medical Books, Inc., 51 East 42nd Street, New York City. 1960. Price $12.00.

* * * *

**FAMILY PLANNING.**—By J. F. Robinson. M. B., Ch. B, with foreword by Sir Andrew M. Claye, M. D., Professor of Obstetrics and Gynecology, University of Leeds. Pp. 64, with numerous illustrations. E. & S. Livingstone Ltd., Edinburgh & London (Exclusive U. S. Agents, The Williams and Wilkins Company, Baltimore 2, Maryland). 1960. Price $1.25.

* * * *

**OBSTETRICS.**—By J. P. Greenhill, M. D., F.A.C.S., F.I.C.S. (Hon.), Senior Attending Obstetrician and Gynecologist, The Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff, The Chicago Lying-in Hospital; Attending Gynecologist, Cook County Hospital; and Professor of Gynecology, Cook County Graduate School of Medicine. Pp. 1098, with 1219 illustrations on 903 figures. Twelfth Edition. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1960. Price $17.00.

When the oak is felled the whole forest echoes with its fall, but a hundred acorns are sown in silence by an unnoticed breeze.—Thomas Carlyle.


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# Correspondence

AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street
Chicago 10, Ill.

September 9, 1960

Mr. Charles Lively, Executive Secretary
West Virginia State Medical Association
Charleston 24, West Virginia

Dear Mr. Lively:

I would like to take this opportunity to thank you and your staff, as well as members and officers of the Medical profession and others in West Virginia, who cooperated so splendidly these past two years in the effort to defeat Forand-type legislation.

It would be my personal wish to be able to write each individual member of your organization, to express my appreciation for their cooperation in winning this important battle for American Medicine, but I am sure you realize that this task would be most difficult in view of the many persons who participated in this victory.

Certainly, your membership must recognize and appreciate your efforts, as does the leadership of the American Medical Association. Without your generous cooperation, this result could not have been achieved.

Each report on West Virginia from our Field Representative, Joe D. Miller. indicated not only full cooperation from your office, but also valuable support from other organizations. I also read many friendly editorials taken from some of your local newspapers and these undoubtedly played a significant role in the total campaign.

For all these things, I am indeed grateful. Please relay my personal thanks to all in your state who helped make this effort successful.

Sincerely yours,
(Signed) F. J. L. Blasingame, M. D.
Executive Vice President

FJLB:hr

## A Great Service We Must Continue

The house of medicine was built from the sweat and toil, the heart and soul, of men of another decade whose tedious and heart-breaking experiences made them stronger and better for the challenge that lay before them. Their compensation many times was only the stars they might receive in their crown when they went to the great beyond, but these great men with high ideals had the satisfaction of knowing that they had served their neighbors and friends with dignity and honor.

Let us emulate these men of that bygone era. We must continue to uphold our profession as a great service to all mankind. Let us again revive and revitalize the Oath of Hippocrates.—E. D. Sorenson. M. D., in Wisconsin Medical Journal.


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## Rehabilitation in Industry

The rehabilitation of the handicapped and the more efficient utilization of this manpower in industry are both a responsibility and an opportunity to those who shape personnel policies in industry, those in charge of industrial health and safety, physicians and paramedical personnel specializing in rehabilitation, the community at large, industry, unions, and government.

Today we are able to do more than ever before in overcoming the crippling after-effects of injury, disease, and congenital deformity. The advances of medical knowledge in recent years and research activities in accredited rehabilitation institutions enable us to evaluate the soundness of policies and procedures better, to verify that which is sound and to reassess factors that are negative in results.

Thus it is possible to offer new hope to thousands of people who, even less than a generation ago, would have been written off as beyond help. The support of those close to them and all others concerned with the welfare of their fellow citizens may now take on new dimensions. While many people are progressively becoming aware of what can be done in the realm of rehabilitation, they may still be inclined to think of it as an expensive service evolved solely from an altruistic feeling.—G. Gingras, M. D., and G. Gagnom, M. A., in Canadian Medical Association Journal.

---

Action without knowledge is foolish, but knowledge without action is futile.—Anon.

## Deaths from Football

The American Football Coaches Association reported that there were 108 deaths from football during the five year period, 1955-59. Eighty-one sustained the injury from tackling or blocking while actively engaged in playing. There were 51 high school players in this group. Several deaths occurred among sandlot players and at least one a year among professionals, excepting those in the National Football League. They had no fatalities during this time.

The remaining 27 deaths were caused by factors not related to body contact, such as heat stroke and heart failure.—Illinois Medical Journal.

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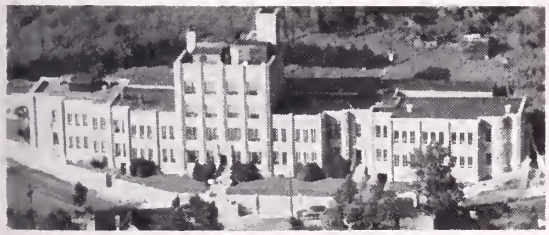

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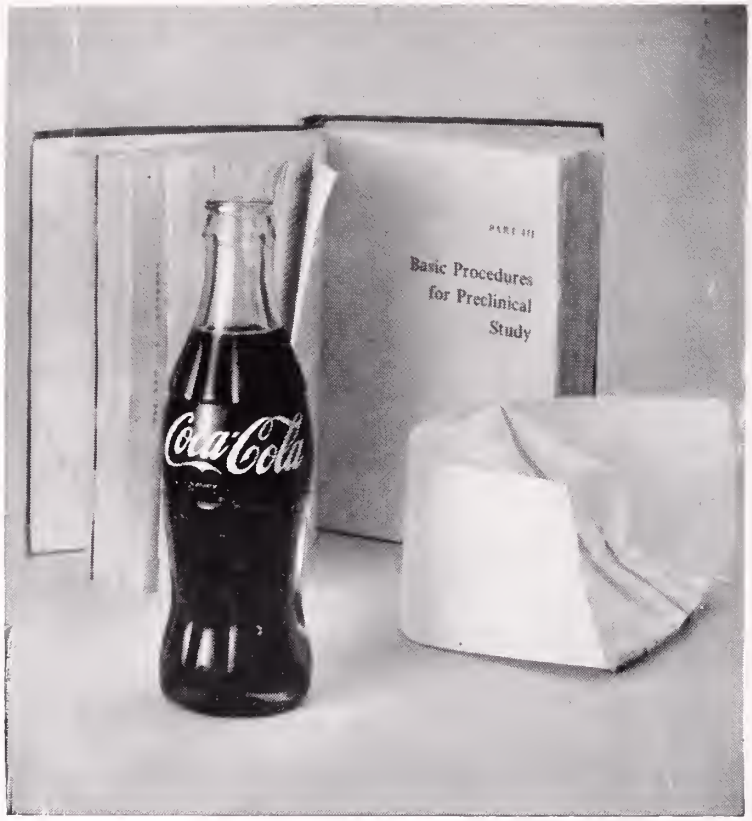


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## Clinging to Old Habits

One of the factors involved in the diminished capacity of many older individuals to adjust easily and quickly to new situations is an extension of something which happens to all of us every day. We know, for example, that a two-year-old youngster can learn French or Chinese just as easily as he can learn English. After he has learned English, however, it is no longer as easy for him to learn French or Chinese and the older he gets, the harder it will be. This is not because he is less intelligent. It is because once we have learned something and have established a pattern for ourselves, we tend to use this pattern automatically under stress.

Trying to learn something new is stressful and we not only have to learn the new thing but, literally, to unlearn or at least get out of the habit of automatically using the old. The more years we live, the more patterns we have crystallized into rigid, semi-automatic sequences and the more difficult it is to abandon them. There is strong temptation for all of us to take the easier way and to cling to the old habits of thought and attitude. The elderly person is especially likely to do that.—James N. Sussex, M. D., in Journal, Med. Assn., State of Alabama.

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| Barbour-Randolph-Tucker | Samuel C. Johnson | Parsons | Charles L. Leonard | Elkins | 3rd Thurs. |
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| Brooke | James E. Wise | Follansbee | H. L. Hegner | Wellsburg | |
| Cabell | I. Ewen Taylor | Huntington | W. L. Neal | Huntington | 2nd Thurs. |
| Central West Virginia | Harald D. Almand | Buckhannon | R. L. Chamberlain | Buckhannan | As Scheduled |
| Eastern Panhandle | George F. Pugh | Martinsburg | F. A. Hamilton, Jr. | Martinsburg | Quarterly |
| Fayette | Thomas C. Sims | Longacre | Marvin Kirsh | Montgomery | 1st Wed. |
| Greenbrier Valley | E. T. Cobb | Ronceverte | James Hamilton | Marlinton | 2nd Wed. |
| Hancock | George Naymick | Weirton | Arthur Phillips | Weirton | 2nd Tues |
| Harrison | Richard V. Lynch, Jr. | Clarksburg | Andrew J. Weaver | Clarksburg | 1st Thurs. |
| Kanawha | Milton J. Lilly | Charleston | A. B. Curry Ellison | Charleston | 2nd Tues. |
| Logan | Ray M. Kessel | Logan | Luke Combs | Man | 2nd Wed. |
| Marion | S. L. Stillings | Mannington | G. Thomas Evans | Fairmont | Last Tues. |
| Marshall | H. B. Ashworth | Moundsville | J. W. Myers | Moundsville | Semi-Ann. |
| Mason | C. Leonard Brown | Pt. Pleasant | Dan Glassman | Pt. Pleasant | |
| McDowell | Guy E. Irvin | Welch | George L. Fischer | Welch | 2nd Wed. |
| Mercer | W. E. Copenhaver | Bluefield | John J. Mahood | Bluefield | 3rd Mon. |
| Mingo | Frank J. Burian | Williamson | Russell A. Salton | Williamson | 2nd Thurs. |
| Monongalia | David Z. Morgan | Morgantown | C. A. Logue | Morgantown | 1st Tues. |
| Ohio | S. S. Bobes | Wheeling | H. G. Dickie | Wheeling | 4th Tues. |
| Parkersburg Academy | Jack J. Stark | Belpre, Ohio | Robert M. Biddle | Parkersburg | 1st Thurs. |
| Potomac Valley | P. R. Wilson | Piedmont | H. L. Eye | Franklin | 2nd Wed. |
| Preston | John F. Lehman | Kingwood | C. Y. Moser | Kingwood | 4th Thurs. |
| Raleigh | F. Vivan Lilly | Beckley | Preston C. Davis | Beckley | 3rd Thurs. |
| Summers | Jack D. Woodrum | Hinton | A. W. Holmes | Hinton | 3rd Wed. |
| Taylor | R. D. Stout | Grafton | Herbert N. Shanes | Grafton | Last Thurs. |
| Wetzel | Lemoyne Coffield | New Martinsville | C. P. Watson, Jr. | New Martinsville | Monthly |
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## A Roadblock to Medical Education

Every thoughtful physician and student of medical education must seriously consider the implications of the present-day, woefully inadequate supply of anatomical material in the medical schools in Massachusetts. The subtitle of this paper suggests that this problem is, in general, to be approached, understood and activated along at least three avenues—Man, God and Law.

Bioanatomy, it is conceded, is not ancillary to the various components of the medical curriculum; on the contrary, it is considered to be fundamental, or better, interstitial in the frame of studies for the training of undergraduate medical and dental students. Although the public demands that a physician should have a thorough knowledge of the structure of the human body, it is unfortunately true, nevertheless, that the opportunity to obtain this knowledge is precluded by the lack of sufficient cadavers. For example, the three medical schools in this State do not receive the minimum of fully usable unclaimed bodies for instruction to the undergraduate medical and dental classes. Such being the case, it is understandable why no cadavers are available for those in residency-training programs in hospitals; for schools of embalming; for practicing physicians and surgeons; and for students at the paramedical schools—nurses, physiotherapists, occupational therapists and so forth.

The physicians of Massachusetts know that if the present shortage of cadavers continues, the opportunity for a thorough knowledge of bioanatomy, which is frequently the only means for the preservation of life and for the prevention of deformities, is inexcusably unattainable. In this connection, the interest in the growth of the concept of rehabilitation points up the value of bioanatomy. This is also true in the significant area of the replacement of arteriosclerotic segments in the great vessels of the human body. Further, in instances of poliomyelitis and of cleft lip or cleft palate, it seems clear that the anatomical deformity is not alone a private matter, but more frequently a bioanatomic communal matter.

The problem of the procurement of adequate anatomical material for the promotion of the common good is a social enterprise for both the public and the anatomists. In recent years, there has been a striking increase in the number of people who desire to donate their bodies after death for the promotion of anatomical science. The quality of empathy is probably the key motivation in their desire to benefit medical science by leaving their bodies to medical schools. We are all familiar with the reasonably common practice of people who donate parts of their bodies to the eye, bone, cartilage, fascia and artery banks. It would seem that the key quality of empathy is as significant in the twentieth century as were the key words of evolution, reason, and God in the nineteenth, eighteenth and thirteenth centuries respectively.—Benjamin Spector, M. D., in Massachusetts Physician.

---

A good thing to remember, and a better thing to do, is to work with the construction gang and not with the wrecking crew.—John Ruskin.


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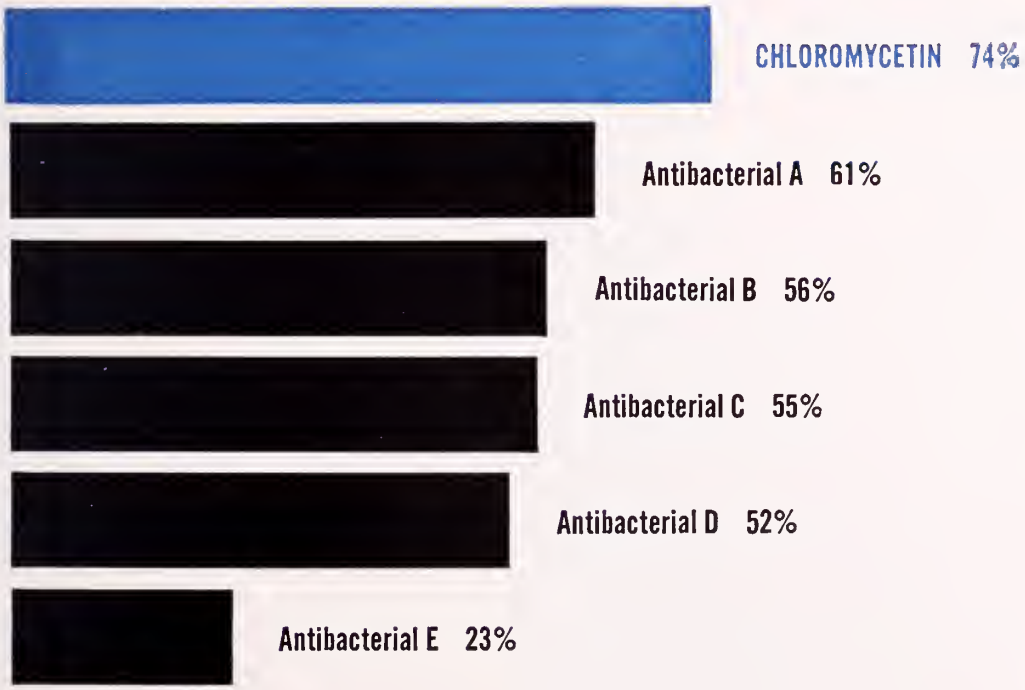


*Adapted from Goodier & Parry[1]

NOVEMBER
1960

Vol. 56 No. 11

# The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone Dickens 4-4625.

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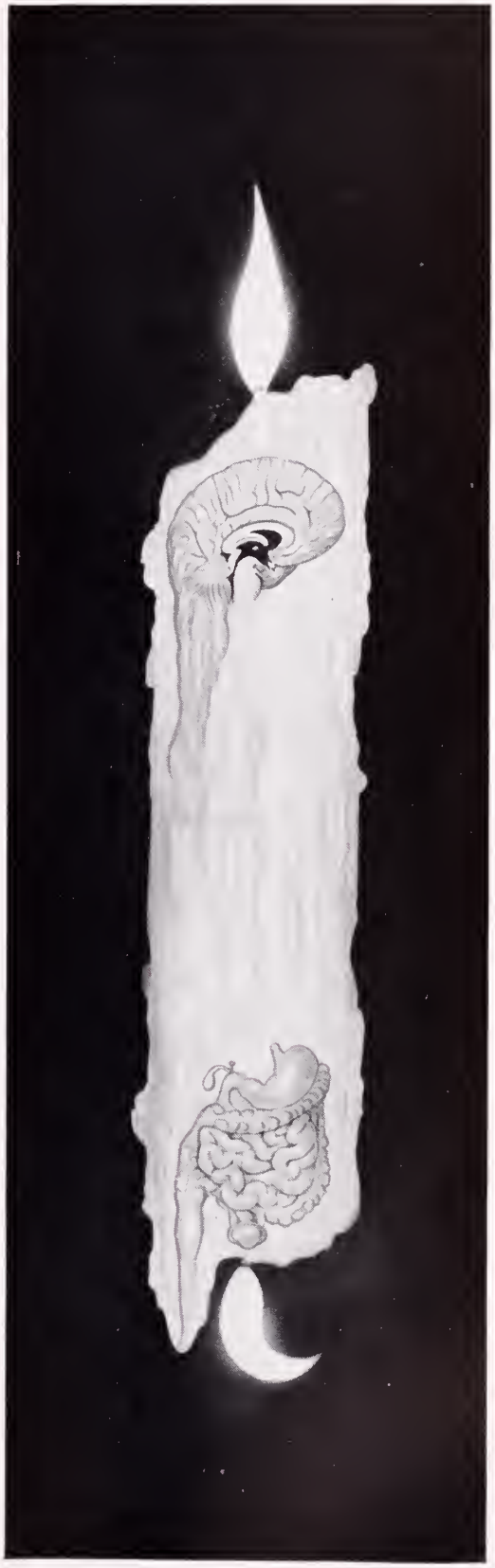

# WVU Medical Center
# —News—

• Compiled from material furnished by John B. Harley, M. D., Assistant Professor of Medicine and Public Information Officer at the WVU Medical Center in Morgantown, W. Va.

Dr. Byron M. Bloor of Cleveland, Ohio, has accepted appointment as Associate Professor of Surgery and Chairman of the Division of Neurosurgery at the West Virginia University School of Medicine. The appointment was announced last month by University President Elvis J. Stahr, Jr.

He has served since 1957 as assistant professor of neurosurgery at the Western Reserve University School of Medicine, and as chief of neurosurgical service at Cleveland City Hospital.

A native of Idaho, Doctor Bloor was graduated from the University of Idaho and received his M. D. degree from the Duke University School of Medicine in 1945. He interned at Duke University Hospital and served residencies there and at the Veterans Administration and Louisville General Hospitals in that city. He was a Damon Runyon Research Fellow at Duke University, 1950-52.

Doctor Bloor was appointed instructor in neurosurgery at Duke in 1952, and associate in 1953. He served in this capacity until he assumed his duties at Western Reserve in 1957.

He was certified by the American Board of Neurological Surgery in 1955. He is a member of the Academy of Medicine of Cleveland, the Ohio State Medical Association and the American Medical Association. He also is a member of several professional societies.

Commenting on the appointment, Dr. Kenneth E. Penrod, Vice President-Medical Affairs, said, "Doctor Bloor is one of the finest young neurosurgeons in the country. He has established himself as a first-rate investigator and teacher as well as a highly competent surgeon. We are indeed fortunate to have a man of such established reputation among neurosurgeons to head the development of this important service at the University Hospital."

### Staff Appointments Announced

Dr. Louis R. Baker of Philadelphia, a member of the faculty at the University of Pennsylvania School of Medicine, has accepted appointment as an instructor in anesthesiology in the Department of Surgery.

He was graduated from the University of Pennsylvania and received his M. D. degree from Jefferson Medical College in Philadelphia. He is a member of several professional organizations.

Dr. William T. Burke, formerly a member of the faculty at Seton Hall University College of Medicine, South Orange, New Jersey, has assumed his duties as assistant professor of biochemistry at the Medical Center.

He was graduated from the University of Rochester and received his Ph. D. from the same institution.

Doctor Burke is currently working on two projects related to cancer and anemia which are financed by a total of $65,000 from the National Institutes of Health, USPHS, and a third, on liver diseases, supported by a $2,000 grant from the Upjohn Company of Kalamazoo, Michigan.

### Research Grants

Dr. Alexander D. Kenny, associate professor of pharmacology, has received a three-year grant totaling $35,000 to finance research on "The Pharmacology of Bone: Mechanisms of Resorption." The grant was made by the National Institutes of Health, USPHS.

The Institutes also awarded the University an $18,975 grant to support a research project by Dr. Edmund B. Flink, professor and chairman of the Department of Medicine. His research study is on "The Role of Magnesium in Human Nutrition."

### Doctor Slack Granted Sabbatical Leave

Dr. John M. Slack, professor and chairman of the Department of Microbiology, has been given the first sabbatical leave ever granted to a faculty member at the University.

Doctor Slack will spend the second semester of the school year studying at European universities and consulting with European microbiologists interested in Actinomyces, a genus of micro-organisms which cause diseases in the oral cavity and other parts of the body.

Sabbatical leaves enable faculty members to receive their regular University salary for a semester while doing off-campus research or study. The program was authorized several years ago by the State Legislature. At least seven years of full-time service at the University are necessary for eligibility.

University President Elvis J. Stahr, Jr., pointed out that most major institutions in this country grant sabbaticals to give outstanding faculty members an opportunity to do research and to keep abreast of the latest developments in their field. He expressed hope that the University will be able to continue and expand the practice in order to aid deserving scholars and to improve the quality of the University faculty.

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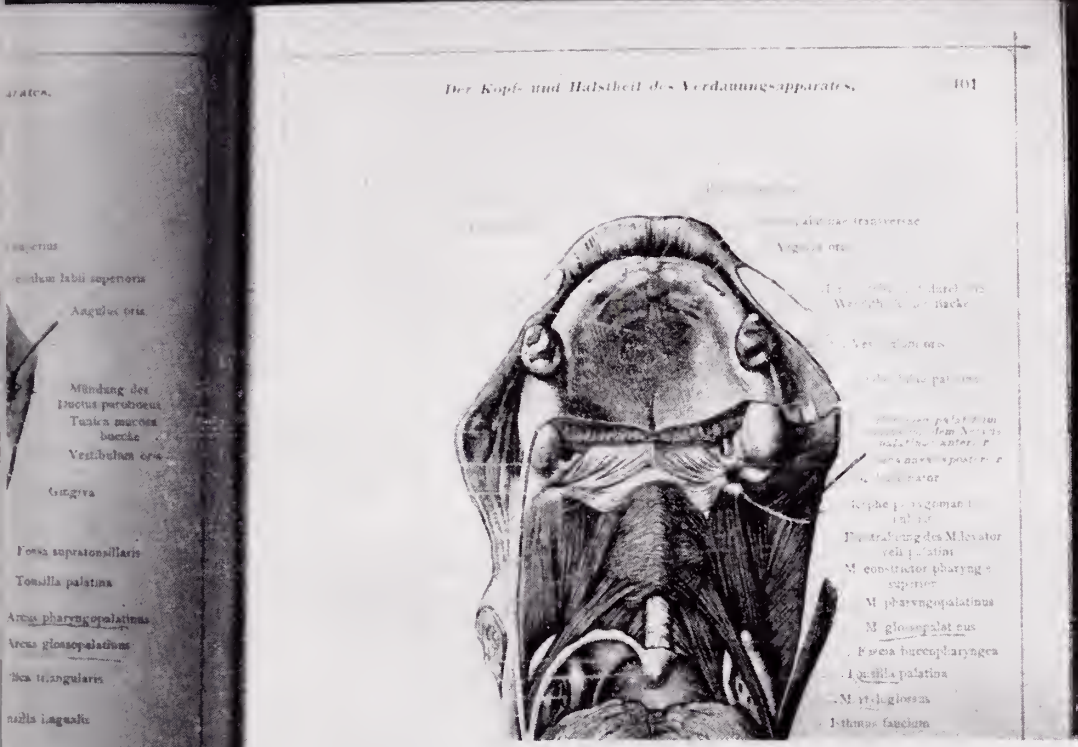


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# The Month in Washington

• From the Washington Office of the American Medical Association.

REPRESENTATIVES of the medical and health professions, the federal government and national civic groups are cooperating in the development of a program for starting the general use of the Sabin live-virus poliomyelitis vaccine next year.

Shortly after clearing the Sabin vaccine for general use, Leroy E. Burney, M. D., Surgeon General USPHS, asked 23 non-government organizations to designate members to serve on a Surgeon General's Committee on Poliomyelitis Control.

An agenda committee met with PHS officials in Atlanta, Oct. 11-12, and drafted a basic agenda for a meeting of the control committee in mid-winter. At the Atlanta meeting, preliminary consideration also was given to administrative and technical problems involved in use of the live-virus vaccine developed by Albert B. Sabin, M. D., of Cincinnati.

The agenda committee was made up of representatives of the American Medical Association, American Academy of General Practice, American Academy of Pediatrics, Association of State and Territorial Health Officers, Children's Bureau, and the National Foundation.

The Sabin vaccine is not expected to be available in substantial quantities before mid-1961.

The chief question is whether the vaccine, which is given orally in the form of pills, liquid or candy, will be administered on individual or mass community basis. The USPHS special committee that recommended approval of the oral vaccine said that the community basis would be better.

"Because of the unique nature of live poliovirus vaccine, with its capacity to spread the virus in a limited manner to non-vaccinated persons, the committee cannot make recommendations for manufacture without expressing concern about the manner in which it may be used," the special committee said.

"The seriousness of this responsibility can be illustrated, for example, by the known potentiality of reversion of virulence of live poliovirus vaccine strains, and the possible importance of this feature in the community if the vaccine is improperly used.

"For example, the vaccine has been employed largely in mass administrations where most of the susceptibles were simultaneously given the vaccine, thus permitting little opportunity for serial human transmission; or, it has been administered during a season of the year when wild strains have usually shown limited capacity for spread. This experience should provide the basis for developing useable practices for the U.S.A."

The special committee also said attention should be given to administration to special groups, such as very young children, pregnant women, and susceptible adults.

The committee was headed by Roderick Murray, M. D., of the National Institutes of Health. Its other members were four M. D.'s and one Ph. D., all of whom were connected with universities except for one M. D. from the USPHS Communicable Disease Center at Atlanta.

Neither the committee nor Doctor Burney anticipated that the live virus vaccine would replace the killed-virus Salk vaccine used since April, 1955.

Dr. Julian P. Price of Florence, S. C., Chairman of the AMA's Board of Trustees, predicted the live-virus vaccine "will be one more powerful weapon against an ancient and crippling disease." He said that physicians "have conscientiously pushed immunization with the Salk vaccine and now, with this new vaccine, the profession is hopeful that even better results can be achieved."

### Health Care for the Aged

Five states were ready soon after the effective date of Oct. 1 to submit plans for participation in the federal-state program of health care for the needy and near-needy aged persons which recently was enacted into law. The states were Arkansas, Michigan, New Mexico, Oklahoma and Washington.

As of early October, another 25 states were preparing to consider legislation to set up such a program or had indicated a willingness to proceed without new legislation. They were Alabama, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Montana, Nevada, New Jersey, North Dakota, North Carolina, Ohio, Pennsylvania, Rhode Island, Utah, West Virginia, Virginia and Wyoming.

Arthur S. Flemming, Secretary of Health, Education and Welfare, urged all states to take part in the program as soon as possible. But he also said he hopes that Congress in the next session will approve a Republican plan for a supplementary federal-state program to help provide private health insurance for elderly persons who cannot meet their medical expenses.

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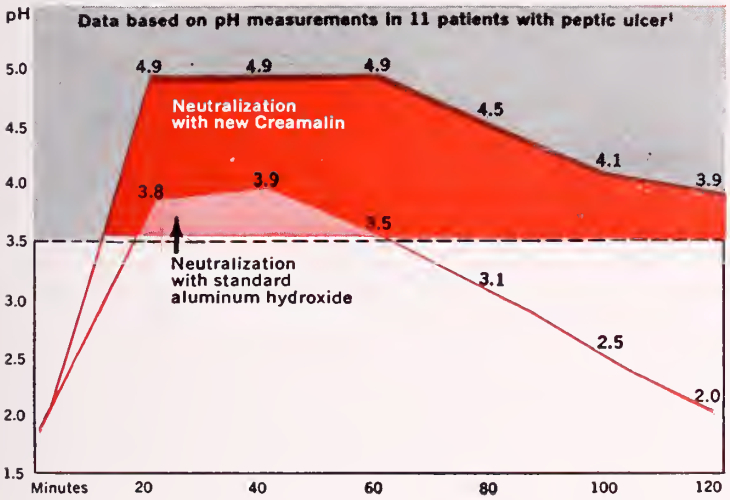


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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: J. Am. Pharm. A. (Scient. Ed.) 48:384, July, 1959.

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# County Societies

### BARBOUR-RANDOLPH-TUCKER

The regular monthly dinner meeting of the Barbour-Randolph-Tucker Medical Society was held at the Philippi Inn, in Philippi, on September 15, 1960.

The guest speaker was Mr. Herbert J. Buhler, professor of psychology at West Virginia Wesleyan College at Buckhannon. His subject was "Psychology of Pastoral Patient Counseling."

The speaker pointed out that the psychological area of pain and bereavement is very important to the physician. He said that one must treat the human organism as not merely a biological specimen but also in relation to sociologic and psychologic factors.

Mr. Buhler pointed out that every operation to a patient is a major one even though it may be termed minor by the physician. He emphasized the team approach and said that ministers are now being trained to help the doctor-patient relationship.

At the business meeting following the scientific program, Dr. Rudolph Hoene was elected to membership in the Society.

The vice president, Dr. J. L. Rittmeyer, presided at the meeting in the absence of the president, Dr. S. C. Johnson. The speaker was introduced by Dr. John Lenox.—Charles L. Leonard, M. D., Secretary.

* * * *

### CENTRAL WEST VIRGINIA

The first Postgraduate meeting sponsored by the Central West Virginia Medical Society was held at the Buckhannon Country Club in Buckhannon on September 22, 1960. The meeting was sponsored by the general practitioners of the society and approved by the AAGP for two hours Credit, Category I.

The morning was devoted to golf, and a scientific program got under way at 3:00 in the afternoon, when the following program was presented:

"The Differential Diagnosis of Jaundice."—Edmund B. Flink, M. D. of Morgantown, Professor and Chairman of the Department of Medicine, West Virginia University School of Medicine.

"Tumors Involving the Extra-Hepatic Bile Ducts"—Bernard Zimmermann, M. D. of Morgantown, Professor and Head of the Department of Surgery, WVU School of Medicine.

A Doctor's Day reception was held on the club patio following the afternoon meeting, at which time red carnations were presented to the physicians present and small carnation corsages to the members of the Auxiliary and guests.

Dinner was served at 6:15 P. M., with 52 members and guests present. Dr. R. L. Chamberlain, who served as moderator at the afternoon session, introduced the guests at the dinner. A gift was presented to Mrs. John W. Hash, wife of the State Medical Association president, and golf prizes to Drs. Ira F. Hartman of Buckhannon, John E. Echols of Richwood, Homer Martin of Daley, and Glenn Ashworth of Morgantown.

The guest speaker at the dinner was Dr. Bernard Zimmermann, whose subject was "The Salt of the Earth."

A program was arranged for the members of the Auxiliary, which included a luncheon in the Colonial Room at Jenkins Hall on the West Virginia Wesleyan Campus. A tour of the college, buildings and grounds followed the luncheon.

Dr. John E. Echols, the President, presided at the business meeting which followed the scientific program in the evening.

Dr. Gerald Jerome Gelford was elected to membership in the Society.

Officers for the new year were elected as follows:

President, Dr. Harold D. Almond of Buckhannon; vice president, Dr. C. R. Davisson of Weston; and secretary-treasurer, Dr. R. L. Chamberlain of Buckhannon.

The following schedule for meetings in 1961 was adopted: April, in Weston; May, Sutton; June, Richwood; July, Webster Springs; and September, Buckhannon.

It was agreed that the Society will sponsor another postgraduate meeting in 1961 to be held in Buckhannon in September. The committee appointed to arrange the program for that meeting is composed of Dr. Ira F. Hartman, chairman, and Drs. J. C. Huffman, R. L. Chamberlain and Harold D. Almond.

The committee on arrangements for the meeting at Weston in April is composed of Dr. Charles T. Lively, chairman; and Drs. Theresa O. Snaith and Elden H. Pertz.—Jane Freeman, M. D., Secretary.

* * * *

### McDOWELL

An interesting motion picture on the method used by Social Security officials to determine disability was shown at the regular monthly meeting of the McDowell County Medical Society, held at Grace Hospital in Welch on September 14. The program was presented by the Disability Determination Section of the State Office of Vocational Rehabilitation.

At the business meeting held after the scientific program, Drs. R. O. Gale, Charles F. McCord and William J. Berry were elected to membership in the Society.

The President, Dr. Guy E. Irvin, presided at the meeting which was attended by 25 members and guests.—George L. Fischer, M. D., Secretary.

* * * *

### MERCER

Dr. Samuel Kaplan, Assistant Professor of Pediatrics and Head of the Department of Pediatric Cardiology at the University of Cincinnati College of Medicine, was the guest speaker before the Mercer County Medical Society at the regular monthly meeting held at the University Club in Bluefield on September 19.

An interesting motion picture on open heart surgery was shown by the speaker, who discussed the importance of the heart-lung machine in these operations. He said that the future of heart surgery with new advances is very promising.

Dr. N. Allen Dyer, County Health Officer, introduced Dr. Robert Price of the United States Public Health

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Service who explained the proposed research project to study uncomplicated hypertension. The purpose of the study would be to ascertain if treatment would alter the natural course of the disease.

Following Doctor Price's address, it was ordered that a committee be appointed to work with the health department on the project. The president, Dr. W. E. Copenhaver, appointed as members of the committee, Dr. Upshur Higginbotham, chairman; and Drs. Henry Warden, Sam Milchin, J. R. Shanklin and Daniel Hale. The committee was asked to present recommendations at the next meeting of the Society.

The president also announced the appointment of Dr. Richard O. Rogers, Jr., as chairman of the Committee on Diabetes.

Another committee was appointed for the purpose of aiding in the establishment of a nursing home in the Bluefield area. This committee is composed of Drs. J. I. Markell, Sam Milchin and E. Lyle Gage.

Prior to the opening of the meeting following the dinner hour, all of the members stood for a minute of silent prayer in memory of the late Dr. R. V. Shanklin and Dr. H. R. Connell.—John J. Mahood, M. D., Secretary.

* * * *

### RALEIGH

Dr. Jack A. Vermeeren of Beckley was the guest speaker at the regular monthly meeting of the Raleigh County Medical Society which was held at the Beckley Hotel in that city on September 15.

The speaker, who is gynecologist and obstetrician at Beckley Memorial Hospital, presented an interesting paper on the various aspects of gynecologic problems confronting general practitioners.

During the business session which followed Doctor Vermeeren's paper, Dr. Charles Richard Daniel was elected to membership in the Society.

Dr. F. Vivan Lilly, the president, presided at the meeting which was attended by more than fifty members.—Preston C. Davis, M. D., Secretary.

* * * *

### WYOMING

Dr. Florine Hampton, of the vocational rehabilitation section of the Social Security Office in Charleston, and Mr. George Hess, field representative of the office in Welch, were guest speakers before the regular monthly dinner meeting of the Wyoming County Medical Society, held September 25 at the Cow Shed near Pineville.

The speakers interspersed their remarks with the showing of a film on Social Security procedure, and a second film under the title, "Why Some People Are Turned Down, Even Though Eligible."

Dr. A. J. Villani and Dr. R. H. Edwards of the Stevens Clinic Hospital staff in Welch presented a case history on "Placenta Accreta." Color slides were used by the speakers.

Doctor Villani reported from "tidbits" gathered by him while at Duke University concerning old customs and sayings of mid-wives in various sections of the country.

The president, Dr. E. M. Wilkinson, presided at the business session which followed the scientific program. —R. E. Newman, M. D., Secretary.

# *Woman's Auxiliary*

**to the**

**WEST VIRGINIA STATE MEDICAL ASSOCIATION**

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### 17th ANNUAL CONFERENCE IN CHICAGO

The seventeenth annual conference of State Presidents, Presidents Eleet, National officers, and chairmen of the Woman's Auxiliary to the American Medical Assoeiation was held at the Drake Hotel in Chicago, October 2-5.

The Woman's Auxiliary to the West Virginia State Medical Association was represented by Mrs. Charles L. Goodhand of Parkersburg, treasurer of the AMA Auxiliary; Mrs. Clark K. Sleeth of Morgantown, president of the State Auxiliary; and Mrs. Vernon L. Dyer of Petersburg, president elect.

Mrs. Harlan English of Danville, Illinois, president elect of the AMA Auxiliary, presided at the conference, and the address of welcome was delivered by the president, Mrs. William Mackersie of Detroit, Michigan. The theme for the three-day meeting was "Accent Service to Preserve and Enhance the Heritage of American Medicine."

Interesting features included a skit, "At the Bridge Table," which dealt with community service in action; a public opinion interview concerning the doctor's wife in the community; and discussions on mental health and health careers which pointed out the many ways these important services may be promoted.

Another session was devoted to membership and was conducted by the four regional chairmen. It was noted that approximately half of the wives of physicians in the country are members of the Auxiliary, and that physicians could assist the Auxiliary by urging their wives to become members.

Speakers on the program included Dr. Edward R. Annis of Miami, Florida, who outlined AMA legislative activities; Dr. Granger W. Westberg of Chicago, who spoke on "Frontiers in Religion and Medicine;" and Mr. Robert M. Hanson of Battle Creek, Michigan, whose subject was "Shelters for Survival." Mr. Hanson said that in interviews with young people, eight out of ten indicated they would rather have a bomb shelter than a swimming pool. On the other hand, older people interviewed were more prone to feel that survival was not an immediate danger.

Representatives of the American Medical Association who appeared on the program included Dr. Leonard W. Larson, president elect; Dr. F. J. L. Blasingame,

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SUMMIT, N. J.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955. /2830MB

Complete information available on request.

executive vice president; Dr. Ernest B. Howard, assistant executive vice president; Dr. George F. Lull, president of the AMEF; Dr. Fred A. Humphrey, chairman of the Council on Rural Health; and Mr. C. Joseph Stetler, director of the Law Division.

The conference was well attended by representatives from every state and the sessions were stimulating and instructive. The West Virginia representatives feel that our county auxiliaries compare favorably with the best the other states have to offer in service to our communities and to the medical profession.—Mrs. Vernon L. Dyer, President Elect.

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### HANCOCK

Mrs. Roy G. Conrad of Weirton presided at the regular monthly meeting of the Woman's Auxiliary to the Hancock County Medical Society which was held at the Williams Country Club in Weirton on September 20.

The Auxiliary voted to make its usual annual contribution to the medical library at Weirton General Hospital. It was also decided to make an appeal to the general public for funds to support the library, inasmuch as this is the chief project undertaken by the Auxiliary during the year.

It was reported that seven children in the Hancock County Children's Home were remembered with birthday gifts during the summer months.

Mrs. Thomas G. Harper served as hostess for the meeting, which was attended by 12 members.—Mrs. Eli J. Weller, Correspondent.

* * * *

### HARRISON

Mrs. G. Thomas Evans of Fairmont, a past president of the Woman's Auxiliary to the West Virginia State Medical Association, and presently a member of the Governor's Commission on Problems of the Aging, was the guest speaker before a dinner meeting of the Auxiliary to the Harrison County Medical Society held at the Stonewall Jackson Hotel in Clarksburg on October 6. Her subject was, "Care of the Aging."

Hostesses for the meeting were Mrs. E. Ross Allen and Mrs. Paul E. Gordon. Out of town guests present included Mrs. J. C. Huffman of Buckhannon and Mrs. E. Lyle Gage of Bluefield.

Mrs. Herman Fischer, the president, presided at the meeting and the speaker was introduced by Mrs. C. S. Harrison, program chairman.—Mrs. Paul E. Gordon, Correspondent.

* * * *

### MARION

Mrs. Clark K. Sleeth of Morgantown, president of the Woman's Auxiliary to the West Virginia State Medical Association, was the guest speaker at the annual membership meeting of the Woman's Auxiliary to the Marion County Medical Society which was held at the home of Dr. and Mrs. Claude S. Lawson, Jr., in Fairmont, on September 29.

Another guest at the meeting was Mrs. George A. Curry of Morgantown, second vice president of the State Auxiliary.

Mrs. John D. Lindsay, Jr., president of the local auxiliary, presided at the business meeting.

Hostesses for the meeting were Mesdames John P. Trach, William T. Lawson, Robert B. Hamilton, F. W. Mallamo and Phillip Johnson.—Mrs. John J. Coogle, Correspondent.

* * * *

### McDOWELL

Mrs. Clark K. Sleeth of Morgantown, president of the Woman's Auxiliary to the West Virginia State Medical Association, was the guest speaker at a luncheon meeting of the Woman's Auxiliary to the McDowell County Medical Society which was held at the home of Dr. and Mrs. A. J. Villani in Welch on September 21.

Mrs. Sleeth presented a very interesting talk following the theme of the State Auxiliary for the current year, "Promoting an Awareness of the Auxiliary."

Mrs. Pat A. Tuckwiller of Charleston, third vice president of the State Auxiliary, was also a guest at the meeting. Gifts were presented to Mrs. Sleeth and Mrs. Tuckwiller, and Mrs. Dante Castrodale, immediate past president of the local auxiliary.

Mesdames John S. Cook, David J. Skewes and A. J. Villani served as hostesses for the luncheon meeting.—Mrs. J. Hunter Smith, Correspondent.

* * * *

### MERCER

The regular monthly meeting of the Woman's Auxiliary to the Mercer County Medical Society was held at the Bluefield Country Club in that city on September 19. Mrs. R. R. Raub, the president, presided.

Reports of various committees were presented during the meeting and Mrs. Charles G. Thedieck presented an interesting report on the annual meeting of the State Auxiliary which was held in August at The Greenbrier in White Sulphur Springs.

It was announced that Dr. Joseph Marsh, president of Concord College, will be the guest speaker at the October meeting.—Mrs. William F. Hillier, Jr., Correspondent.

* * * *

### MINGO

Mrs. W. H. Price, president of the Auxiliary to the Mingo County Medical Society, was hostess to the members at the regular monthly meeting in the King Coal Room of the Mountaineer Hotel in Williamson on September 22.

Two new members were introduced at the meeting. They are Mrs. Carl J. Greever and Mrs. T. Montgomery, both of Williamson.

The Auxiliary was represented at the Annual Meeting at White Sulphur Springs in August by Mrs. Robert Tchou and she submitted a report concerning the proceedings. The basic theme emphasized by the Auxiliary during the past year and at the Convention was "Continuity in the Furtherance of Better Health."

Attractive club yearbooks were distributed to the members during the meeting.—Mrs. Robert J. Tchou, Correspondent.

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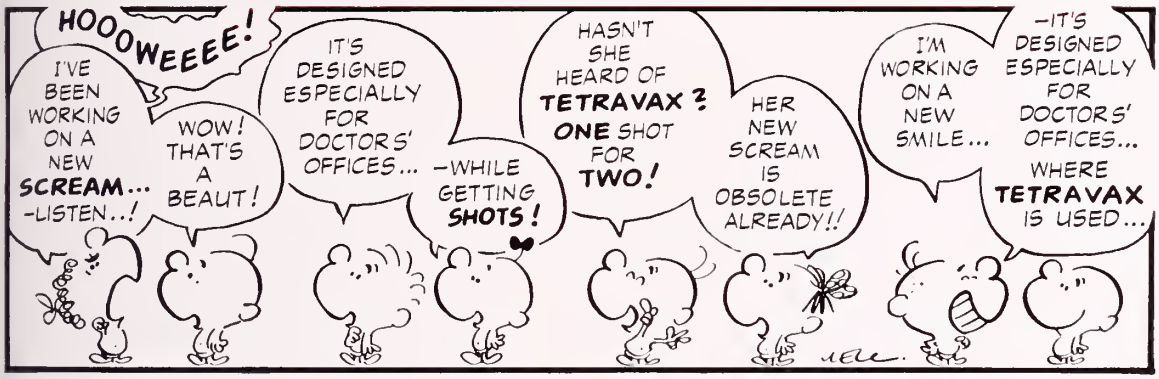


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### MONONGALIA

The wives of the new physicians named to the faculty of the West Virginia Medical Center were entertained as special guests at the annual coffee sponsored by the Woman's Auxiliary to the Monongalia County Medical Society at the home of Dr. and Mrs. Maynard Pride in Morgantown late in September.

The special guests included Mesdames Bernard Zimmermann, Edmund Flink, Herbert Warden, William E. Anderson, W. Gene Klingberg, Nicholas W. Fugo, Edward G. Stewart and Franklin Milam. The guest list also included Mrs. W. G. Oliphant and Mrs. John B. Harley.

Hostesses for the event were Mesdames French Miller, C. A. Logue, B. M. Stout, Jr., Robert Greco, Carl H. Cather and Maynard Pride. The floral arrangements visible throughout the Pride home were created by Mrs. Lucien Strawn.

Besides the special guests, the coffee was attended by 32 members of the Auxiliary.—Mrs. Maynard Pride, Correspondent.

* * * *

### OHIO

New members of the Woman's Auxiliary to the Ohio County Medical Society were honor guests at a tea given last month at the home of Dr. and Mrs. Joseph L. Curry in Wheeling. Mrs. Robert T. Bandi, the president, presided at the business meeting.

Plans for the coming year were discussed and year books were distributed by Mrs. Herbert G. Dickie, Jr. Mrs. Ross O. Bell, Jr., collected clothing for the "Clothes Chest."

A report of the state meeting held at The Greenbrier in August was presented and it was announced that the local Auxiliary would be represented by five members at the Fall Conference and Board of Directors meeting of the State Auxiliary in Morgantown, October 17-18.

Hostesses for the tea were Mesdames Warren D. Leslie, Andrew J. Niehaus, Earl S. Phillips, Paul H. Cope, Robert S. Robbins and E. Lee Jones.—Mrs. A. J. Barger, Publicity Chairman.

* * * *

### RALEIGH

More than 65 members and guests attended the regular monthly meeting of the Woman's Auxiliary to the Raleigh County Medical Society which was held at the Woman's Club in Beckley on September 19. Mrs. Sherl J. Winter, the president, presided at the meeting and delivered an address of welcome.

The guest speaker at the meeting was Mrs. Clark K. Sleeth of Morgantown, president of the Woman's Auxiliary to the West Virginia State Medical Association. In her address, Mrs. Sleeth urged wives of physicians to serve on health committees in communities throughout the state. She also urged auxiliary members to work with such agencies as the Girl Scouts, Senior Citizens Clubs and Red Cross.

Other guests who attended the meeting were Mrs. Pat A. Tuckwiller of Charleston, third vice president of the State Auxiliary; Mrs. B. W. Steele of Mullens, vice president of the Wyoming County Medical Auxiliary; and Mrs. Hubert A. Shaffer of Morgantown, editor of the State Auxiliary's "News Bulletin."—Mrs. James M. Coram, Correspondent.

# *Book Reviews*

**FRENCH'S INDEX OF DIFFERENTIAL DIAGNOSIS—Edited by Arthur H. Douthwaite, M. D., F.R.C.P., Senior Physician, Guy's Hospital, and Honorary Physician, Westminster Hospital, and All Saints' Hospital for Genito-urinary Diseases, with twenty contributors. Pp. 958, with 774 illustrations, 216 in color. Eighth Edition. The Williams and Wilkins Company, Baltimore 2, Md., exclusive United States Agents. 1960. Price $24.**

This first edition of French's Differential Diagnosis was printed in March 1912 and has been a classic medical book for almost fifty years.

French died in 1951 and the seventh and eighth editions have been edited by H. Douthwaite, assisted by 20 contributors.

The form of the book remains the same. It is an alphabetically arranged list of symptoms beginning with, "accoucheurs hand" and terminating after 958 pages with "weight loss." The index is exhaustive, covering 150 pages of 4-columned finely printed items.

The book is described in the first edition as a "treatise in the application of differential diagnosis to all the main signs and symptoms of disease" and this purpose is duly maintained in the eighth edition. As the author states, "the basic principles of bedside diagnosis do not change substantially and the purpose of the work which is to help the practitioner faced with a difficult problem, to arrive at a diagnosis, is preserved."

It is difficult to consider any symptom, however rare, without finding it in the index and a reference to several headings. The main references are in heavy type.

Some readers may find the type too small. Better reading might be accomplished by dividing the page into 2 columns.

French's Index will make a valuable and frequent reference for many physicians. This reviewer has used this book for many years and is almost always rewarded when searching for unusual information.—George F. Evans, M. D.

* * * *

**MEDICAL, SURGICAL AND GYNECOLOGICAL COMPLICATIONS OF PREGNANCY—By the Staff of The Mount Sinai Hospital, New York City. Edited by Alan F. Guttmacher, M. D., Obstetrician and Gynecologist-in-Chief, The Mount Sinai Hospital, New York City, and Joseph J. Rovinsky, M. D., Assistant Attending Obstetrician and Gynecologist, The Mount Sinai Hospital, New York City. Pp. 619, with illustrations. The Williams & Wilkins Company, Baltimore 2, Md. 1960. Price $16.50.**

This book shows the superb direction of Alan Guttmacher throughout all the chapters. His is one of the truly creative minds in our specialty today. Never afraid to depart from tradition nor to pioneer a worthy project, this originality sets the background for the volume.

When the Department of Obstetrics was organized at the Mount Sinai Hospital, ten specialty clinics were created within the framework of the Department. These drew freely upon the talents of men in the

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related fields of surgery, medicine, and their subspecialties. For seven years they gained an experience in the medical, surgical and gynecological complications of pregnancy that crystallized in this publication.

Broad topics such as heart disease or tuberculosis with pregnancy are discussed. Also found are almost any and all disease processes that can influence or be influenced by pregnancy, such as ulcerative colitis, optic neuritis, myasthenia gravis, and volvulus.

A copy of this manuscript should be in the library of every hospital where obstetrics is practiced. Physicians who either directly, or indirectly by consultation, manage obstetrical patients will find the book "must" reading.

This book is one of the most important contributions to obstetrical literature in the past 10 years.—John T. Chambers, M. D.

* * * *

**THE ROLE OF THE PHYSICIAN IN ENVIRONMENTAL PEDIATRICS—By Carl C. Fischer, M. D., Professor and Head of the Department of Pediatrics, Hahnemann Medical College and Hospital; and Director of the Health Service, Girard College, Philadelphia, Pa. Pp. 122. 1960. Landsberger Medical Books, Inc., 51 East 42nd Street, New York City. Price $3.50.**

The author has written a short treatise which might be subtitled "What Every New Pediatrician Should Know." Doctor Fischer has discussed the approach to a number of areas which are frequently encountered by physicians who deal with children but which are seldom covered by medical school curricula. As a matter of fact, he implies that the book was evolved from a series of lectures which he gives to his medical students at Hahnemann because physicians have not been participating in these problems.

In seven chapters, which cover a total of 122 pages of large print, Doctor Fischer discusses a number of problems which are quite knotty to the person who must deal with the adoptive child, school health program, handicapped child, and the adolescent. He has formulated from 30 years' experience certain bits of advice which he has passed on to those less experienced.

The author makes a plea for the active role of the physician who sees the child at home to attempt to eradicate the causes of accidents. He stresses the need for the physician to assume responsibility in other fields as well. Certainly the awareness of the doctor caring for the well child to be alert to certain defects is a point well taken by the author. He has a clinician's grasp of the frequency, both of the disease and the pitfalls of diagnosis which fortunately do seem to be appearing less, e.g. Froehlich's syndrome as a diagnosis for the endomorphic adolescent.

If one must be critical, one can point to a defect which is probably unavoidable in a book which is no larger than this, viz., much of the advice on the attitude of the physician toward subjects which involve legal problems is limited by the variation of state laws so that it is necessary for the author to remain general in places where more specific advice would be welcome.

A small criticism is that Doctor Fischer has referred to Doctor Nashpitz' work in two places; however, it is


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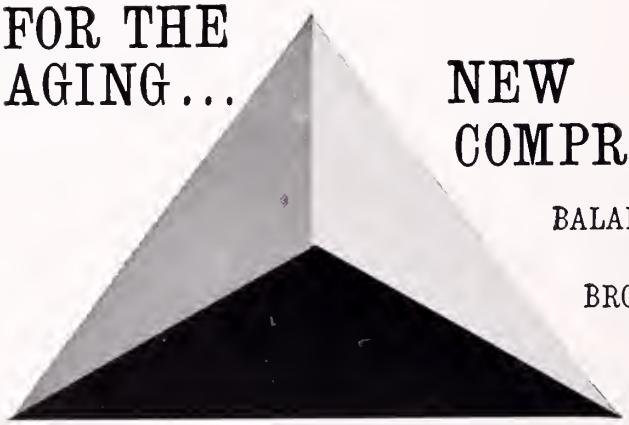

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impossible to find Doctor Nashpitz' name among the references given, but it is probable that he is one of the authors of publications which do not bear the names of the individuals contributing.

Many of us could read this little book in about three hours, perhaps less for a fast reader. I would recommend it for those interested in pediatrics; however, those who will obtain the most value from the book will be the physicians about to enter practice, because they might be alerted to some of the problems and solutions they may have missed in academic training—Donald M. Burke, M. D.

* * * *

**SIGHT: A HANDBOOK FOR LAYMEN—By Roy O. Scholz, M. D., President of the Eye Section of the Baltimore City Medical Society; Chief of Service of the Department of Ophthalmology in several hospitals in Baltimore and vicinity; and Ophthalmologist-in-Charge of the Johns Hopkins Dispensary. Pp. 166, with illustrations. Doubleday and Company, Inc., 575 Madison Avenue, New York 22, New York. 1960. Price, $3.50.**

This is a remarkably clear and readable presentation in laymen's terms of accurate information about the eyes. Special emphasis is placed on structure, function, diseases, and the manner in which the eye physician examines and treats the eyes. Its 166 pages attempts to answer most of the intelligent questions which patients commonly ask their eye physician.

The well-trained and experienced author has expanded the table of contents to make reference easy. The few technical terms used are defined in a glossary at the end. In spite of lay terminology, the explanations are concise and effective.

In addition to being an eye handbook for the general public, Doctor Scholz' production will have great value to physicians in other medical fields, to nurses, public health and social workers, and to paramedical personnel generally. This book is long overdue and will fill a great need in the field of eye care.—Ralph W. Ryan, M. D.


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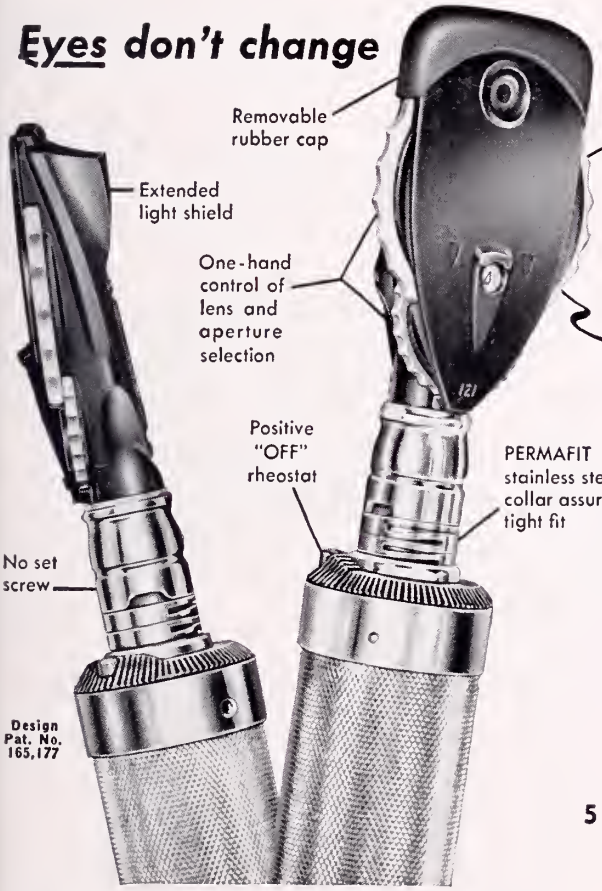


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**CLINICAL MANAGEMENT OF BEHAVIOR DISORDERS IN CHILDREN—By Harry Bakwin, M. D., Professor of Clinical Pediatrics, New York University, visiting physician, Bellevue Hospital and attending pediatrician, University Hospital; and Ruth Morris Bakwin, M. D., Associate Professor Clinical Pediatrics, New York University, visiting physician, Bellevue Hospital, and Director Emeritus, Department of Pediatrics, New York Infirmary. Pp. 597, with illustrations. Second Edition. Philadelphia and London: W. B. Saunders Company. 1960. Price $11.00.**

The first edition of this book is well known to most physicians who treat large numbers of children. There is reason to believe that this edition will be as well, if not better accepted than the previous work. In the words of the authors, they have "sought to distil, from the large amount of material published, the observations in child psychiatry which are well documented and which have been found helpful in understanding and treating healthy as well as problem children." This statement appears in the preface of this edition and it indicates much of the contents.

I think it is important to note the emphasis of a few words in this statement: they have sought to take from a great quantity of material available only those observations which these authors consider well documented. This is worthy of attention because there is a question as to whether or not the psycho-analytically oriented psychiatrist would be as enthusiastic about the book as will the average pediatrician and general practitioner.

It is a book more likely to appeal to those who have a more organic orientation toward medicine. It makes


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much of the functional appear intelligible and for this reason is a comfortable book in the hands of most clinicans.

The book is quite large, embracing 597 pages, and is rather a large bite for one to sit down to read; however, the material is well divided and indexed so that as a reference work it is quite useful. The areas studied include normal growth and development and psychologic care, as well as the disorders we commonly think of in terms of child behavior disorders, such as enuresis, encopresis, abnormal emotional states, anti-social behavior, and certain specific psychotic states. In addition to these there is much about the behavioral aspects of such things as reading and writing difficulties and problems with superior and inferior intelligence. Large parts of the book are devoted to the problems which arise when the child is confronted with challenging situations in school or elsewhere.

A discussion of various tests which are used in psychologic evaluation are of interest to those of us who need to interpret the results of a psychologic examination. There are also sufficient instructions present on the Goodenough "draw-a-man" test to make it feasible for the physician to use the test in his own office as a rough measure of intelligence, and also to obtain an idea of the effect on the child. It is of value to have these collected in one place, under one cover, so that they are available to those of us who do not primarily deal with emotional disorders.

It is possible to quibble in certain places with the authors, such as in their treatment of epilepsy. First, they give only a rather perfunctory discussion of the

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types of epileptic seizure, but it must be granted that the experts in the field of convulsive disorders are not completely agreed on terminology. Second, their discussion of the drug treatment of epilepsy gives rather a short shrift to phenobarbital; although they may be quite correct in the statement of its general ineffectiveness in the control of the behavior disturbances associated, it still probably is the drug of first choice for major motor seizures, as advised by most experts in this field.

If the authors choose to discuss the drug treatment of epilepsy, it might be well to make it more extended. If they feel this is not within the scope of the book it should be omitted completely.

It is heartening to see authorities of this prominence defend such things as discipline and authority. The chapter on Sex Education deserves comment in that it would seem much more compatible with the ideals and morals of our society than much of the disinterested clinical type of discussion which is fostered or encouraged by other authors. Their attitude might be summarized by a few quotations from the work such as "sex instruction should be more than a cold scientific description of the physiology of conception, pregnancy and birth. It should include an understanding of the normal development which occurs during the pre-adolescent and adolescent periods and an explanation of the emotional changes which normally take place.

"Sex Instruction is better given in the home by a trusted parent than in the school or by the physician. Each parent will have his own way of talking to his children. The apprehensive parent will convey his fear and solicitousness, and the embarrassed parent will convey his embarrassment. Nevertheless, by discussing the subject the way will be open for questions. Children value feeling free to discuss their thoughts and doubts about sex with their parents."

The large number of references at the end of each chapter are desirable in such a field where the final answers have not reached the concrete form which they have in some of the more scientific fields of medicine.

This book is one which the physician dealing frequently with children will find of value on his office shelf.—Donald M. Burke, M. D.

## Books Received

**FUNDAMENTALS OF CHEST ROENTGENOLOGY**—By Benjamin Felson, M D., Professor and Director, Department of Radiology, University of Cincinnati College of Medicine; Director of the Department of Radiology at several Cincinnati Hospitals; Special Consultant to the USPHS; and Consultant to the Dayton and Cincinnati VA Hospitals. Pp. 301, with 450 illustrations on 238 figures. Philadelphia & London: W. B. Saunders Company. 1960. Price $10.00.

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Huntington, West Virginia

September 23, 1960

Walter E. Vest, M. D., Editor
The West Virginia Medical Journal
Charleston, West Virginia

My dear Doctor Vest:

A fitting conclusion to a distinguished career was the recent publication of a two volume work on epilepsy by Dr. William Gordon Lennox, with the able assistance of his daughter, Dr. Margaret. "Fittingly," as Doctor Lennox might have said, royalties will be contributed to the organization which he worked so hard to see firmly established—The American Epilepsy Foundation.

As one of many who treasure the memory of Doctor Lennox and the inspiration he gave his younger colleagues, I would like to present the following small tribute:

WILLIAM GORDON LENNOX, M. D.

"William Gordon Lennox in our time has taken epilepsy as his subject of major study, and as a guide to understanding of the brain. He has devoted his life


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to the cause of curing and rehabilitating epileptics, impelled by intellectual curiosity and by Christian compassion."[1] This tribute from Dr. Wilder Penfield, a physician equally impelled in behalf of the epileptic, appeared in the June, 1960, issue of *Epilepsia*, a Festschrift honoring Doctor Lennox. One month later, on July 21, at the age of 76 the beloved physician and inspiring colleague died.

Doctor Lennox began his study of epilepsy at Harvard in 1922 and in 1928 published a monograph on the subject. His collaborator, Dr. Stanley Cobb, has said: "The book is so full of negatives that it is quite dull but the spade work was done. . ."[2] Largely due to Doctor Lennox, either directly through his own work or indirectly through his stimulation of others, the "book" of epilepsy is no longer "full of negatives." Witness his latest work—two volumes on epilepsy published early in 1960.

Of all his work, for which aspect will Doctor Lennox be best remembered?

Will it be his organizational ability—founder and guiding spirit of lay and professional leagues against epilepsy in the United States and abroad, notably the American Epilepsy Federation and the International League Against Epilepsy?

Will it be his scientific achievements, beginning 25 years ago with the classic studies of petit mal epilepsy done in collaboration with Doctors Gibbs and Davis?[3]

Will it be his "twin studies" and other work which punctured the universality of the dictum "epilepsy is inherited?"

Will it be his tireless efforts to improve the social and work life of the epileptic by removing the disease from the dictatorship of the devil to the democracy of all human ills?

Will it be the example of his faith that epilepsy can be cured sometimes, ameliorated always?

In the pages of the medical history books, probably it is Doctor Lennox' scientific achievements that will be stressed. In the life of the epileptic, however, perhaps the answer lies in *The Invisible Wall* by J. W. A. Terrell which says, in part:

"We who are vassals to the Lord Convulsion
All cures are not, and cannot be, enough.
You the unsmitten must know us the smitten
And lose
Your ancient fear of this too mysterious
Yoke we invisibly carry.
Not alone statistics registered and resident
In your higher centers are what we need. . .
As of all lasting good in all
Of us—is the willingness
The simple precious inexpensive
Costly willingness, the willingness to love."[4]

(Signed) M. G. Stemmermann, M. D.

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1. Penfield, Wilder: The Everlasting Whisper, *Epilepsia*, Fourth Series, 1:604 (June) 1960.
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# The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.

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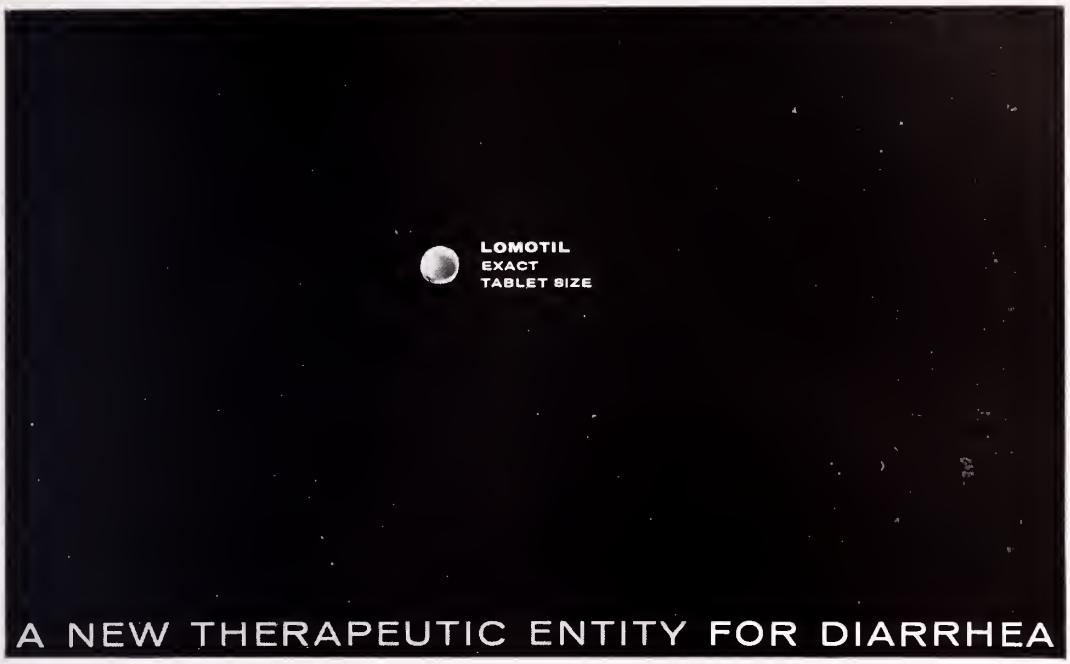


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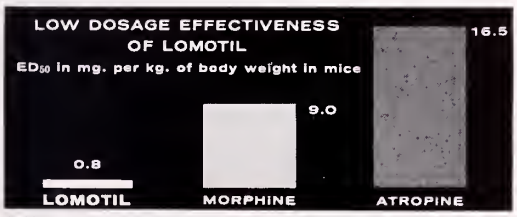


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# WVU Medical Center
# —News—

• Compiled from material furnished by John B. Horley, M. D., Assistant Professor of Medicine and Public Information Officer at the WVU Medical Center in Morgantown, W. Va.

Dr. Rex B. Conn of Minneapolis, Minnesota, has accepted appointment as Assistant Professor of Medicine in charge of the Division of Laboratory Medicine at the West Virginia University School of Medicine. The appointment was announced by University President Elvis J. Stahr, Jr.

Doctor Conn, who is a member of the faculty at the University of Minnesota Medical School, will assume his duties at the Medical Center on January 1. His principal duties will be concerned with organizing and developing clinical laboratories and a blood bank.

A native of Iowa, he holds degrees from four institutions. He was graduated from Iowa State University and received his M. D. degree from Yale University School of Medicine. He received a B. Sc. from Oxford University, England, and an M. S. from the University of Minnesota.

Medical research grant of $5,000 is presented to Dr. Edward J. Van Liere, Dean, West Virginia University School of Medicine, by H. Smedley Walters, right, clinical associate of Wyeth Laboratories of Philadelphia. Looking on is University President Elvis J. Stahr, Jr. The unrestricted grant may be applied to any medical research study.

Doctor Conn is a Diplomate of the National Board of Medical Examiners and has done considerable research in creatine metabolism and its alterations in disease. Several of his articles have appeared in professional journals.

### Assistant Professor of Microbiology Named

Another member of the faculty at the University of Minnesota has been appointed assistant professor of microbiology at the School of Medicine. He is Dr. Samuel J. Deal, who has been serving as instructor in bacteriology and related fields at Minnesota, and prior to that was bacteriologist at the Walter Reed Army Medical Service Graduate School in Baltimore, Maryland.

A native of Knoxville, Tennessee, Doctor Deal received bachelor's and master's degrees from the University of Tennessee, and a Ph. D. from the University of Minnesota. He is a member of several professional societies, including the Society of American Bacteriologists and the American Association for the Advancement of Science.

### Doctor Fugo Named to NIH Committee

Dr. Nicholas W. Fugo, professor and chairman of the Department of Obstetrics and Gynecology, has been appointed to the National Institutes of Health's Pharmacology and Endocrinology Fellowships Review Panel. The appointment was announced by Dr. James A. Shannon, Director of the National Institutes of Health, who was the principal speaker at the dedicatory ceremonies for the Teaching Hospital in October.

The NIH Fellowship program provides individual support for training in the basic and clinical sciences in medical and allied fields. In making the announcement, Doctor Shannon said that recipients of regular fellowship awards are selected on the recommendations of the various fellowship review panels after review and evaluation of individual applications.

Doctor Fugo was appointed to a five-year term ending in September, 1964.

### Research Grants

The School of Medicine has been awarded a five-year research grant totaling approximately $35,000 by the National Institutes of Health, USPHS. The grant will support a study on "The Micro-Circulation of Organs and Tissues" by Dr. C. C. Boyer, associate professor of gross and neurological anatomy, and Dr. T. Walley Williams, chairman of the Department of Microanatomy.

Doctor Boyer said the grant will support studies on the pattern of the micro-circulation of various organs and regions of the body in the normal state with an ultimate aim of investigating alterations in this pattern under various abnormal conditions, produced either experimentally or pathologically.

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# The Month in Washington

• From the Washington Office of the American Medical Association.

THE election of Senator John F. Kennedy as President of the United States means that it is probable that the issue of providing health care for the aged under Social Security again will be raised in Congress next year.

Kennedy will go to the White House pledged to "the immediate enactment of a program of medical care for the aged through Social Security." His intentions present a serious challenge to the nation's physicians who have vigorously opposed use of the Social Security system to provide health care for the aged.

His program would provide what he has described as "a life policy of paid-up medical insurance" for older persons. "It would provide them hospital benefits, nursing home benefits and x-ray and laboratory tests on an out-patient basis," he said in his campaign for the presidency.

He said that the Kerr-Mills legislation enacted into law last summer is inadequate. The medical profession supports this federal-state program to provide health care for the needy and near-needy aged persons. In approving the Kerr-Mills program, Congress rejected the Social Security approach espoused by Kennedy and union labor leaders.

Kennedy's medical program also included federal grants for construction, expansion and modernization of medical, dental and public health schools; federal loans and scholarships for medical students; federal grants for renovating hospitals; increased federal financial support for medical research, including basic research; and expansion of federal programs for rehabilitation of handicapped or disabled persons.

### Clean Bill of Health for FDA Employees

Food and Drug Administration employees have been cleared of conflict-of-interest charges brought up in the Senate Antitrust and Monopoly Subcommittee's investigation of the drug industry.

A three-member investigating group appointed by Arthur S. Flemming, Secretary of Health, Education and Welfare, examined the financial records of 900 FDA employees. The special investigators then reported that "on the basis of all the evidence before us, it is our judgment that there are no present employees of the FDA whose source of personal income are incompatible with their government employment."

The investigators continued to analyze "a mass of fact and opinion" in connection with charges that there has been too close a relationship between some FDA employees and drug companies which they check for conformance to government regulations.

The investigators anticipated that their final report would show the possibility of organization or procedural improvements in the FDA.

The charges were triggered by disclosure at the Subcommittee investigation that Dr. Henry A. Welch, Director of the FDA's Antibiotics Division, had received $287,000 over eight years as a writer and editor for antibiotics publications. After the disclosure, Flemming ousted Welch from the government post.

### Decline in Infant Death Rate

The Federal Children's Bureau reported that while the infant death rate in the United States has declined since 1958 it still shows the effect of a 1957-'58 setback.

There was a steady decline in U. S. infant deaths during the 1950's but increases noted in 1957 and 1958. Since then, the infant death rate has headed downward again but still hasn't made up the lost ground, even though the provisional rates for 1959 (26.4 deaths under one year per 1,000 live births) and the first half of 1960 (25.9 per 1,000) showed improvements.

In 1915, when data were first gathered on infant mortality in this country, the rate was 99.9 per 1,000. By 1940, this had been cut to 47, and by 1950 it had been reduced to 29.2.

An all-time low of 26 was registered in 1956. It edged up to 26.3 in 1957 and 27.1 in 1958.

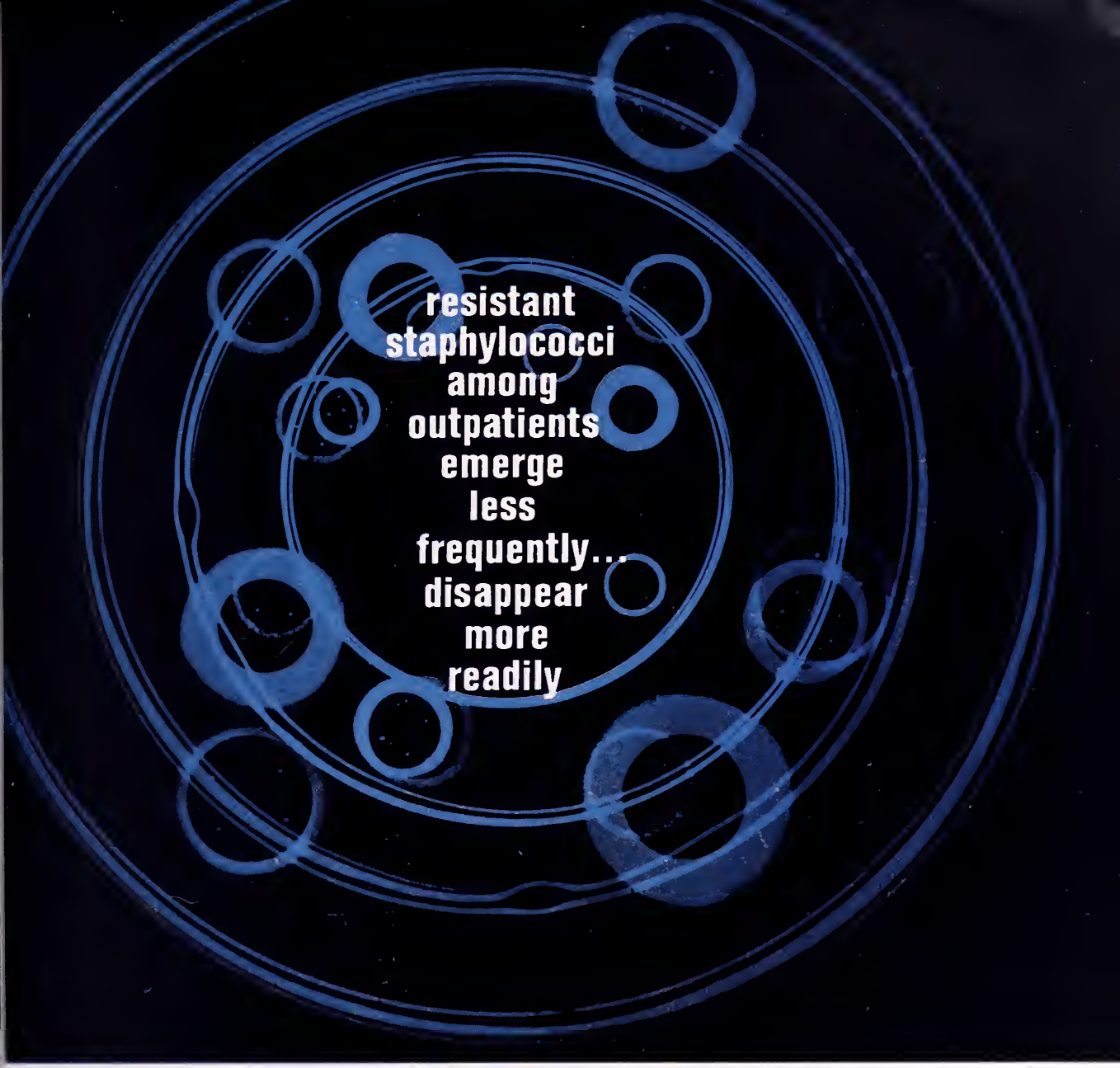
According to the 1959 United Nations Demographic Yearbook, nine other countries reported lower infant mortality rates than the United States in 1958. They were Sweden 15.8, Netherlands 17.2, Australia 20.5, Norway 20.5, Switzerland 22.2, United Kingdom 23.3, Denmark 23.4, New Zealand 23.4 and Finland 24.5.

Russia reported a rate of 81 in 1950 and 40.6 in 1957, latest year for which data are available.

### Routine Vaccination Against Influenza

Persons with heart and blood vessel diseases have been urged to consult their physicians about routine vaccination against influenza.

In a joint statement, the American Heart Association and the National Heart Institute of the U. S. Public Health Service said that "evidence of the past three years abundantly confirmed that dangers of influenza are much greater for patients with heart or lung disease than for others."

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*Adapted from Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* **173**:475, 1960.

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# Obituaries

### GUSTAVUS BENZ CAPITO, M. D.

Dr. Gustavus Benz Capito, 82, of Charleston, died in a Middletown, Ohio hospital on October 30. He had been in that city visiting a sister, Mrs. Bertha C. Schmidt. Death was attributed to a cerebral hemorrhage.

Doctor Capito was born in Charleston on January 25, 1878. He was a graduate of Washington and Lee University and received his M. D. degree from Columbia University College of Physicians and Surgeons, New York City, 1903. He interned at St. Lukes Hospital, New York City, and Charity Hospital in Berlin, Germany. In addition, he had postgraduate work both in Berlin and Vienna.

After practicing at White Sulphur Springs until 1917, he moved to Charleston, where he remained in active practice until his retirement in 1958.

In 1939, he was named president and medical director of Kanawha Valley Hospital, a post he held until January 1959, when he established and turned over his entire holdings in the hospital to the Charleston Foundation for Medical Research and Education. He remained at the hospital as counselor without pay.

As a result of a gift of $16,000 from the Foundation, a special chair for research in the field of cancer and tumors was established at the West Virginia University Medical Center. Announcement of the gift was made jointly last August by Doctor Capito and University President Elvis J. Stahr, Jr.

He had made substantial contributions to his Alma Mater, Washington and Lee University, and in 1954 was cited by Columbia University for outstanding services to his profession. That same year, he was named by Governor William C. Marland as delegate from West Virginia to the World Medical Association in Richmond, Virginia.

He served as Captain in the Medical Corps of the Army during World War I.

He was an honorary member of Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Besides his sister, Mrs. Schmidt, he is survived by two nieces and four nephews.

* * * *

### ARCHIBALD PERRIN HUDGINS, M. D.

Dr. Archibald Perrin Hudgins, 58, of Charleston, died October 27, 1960, following a short illness.

Doctor Hudgins was born in Richmond, Virginia, May 31, 1902. He received his B.S. degree from Davidson College in North Carolina in 1924 and his M. D. degree from the Medical College of Virginia in 1928. He served his internship at Sheltering Arms Hospital in Richmond and a residency at Hinton Hospital, 1928-1934.

He had postgraduate work at Meredith House, and the New York Cancer Institute, Bellevue Hospital, 1934-37.


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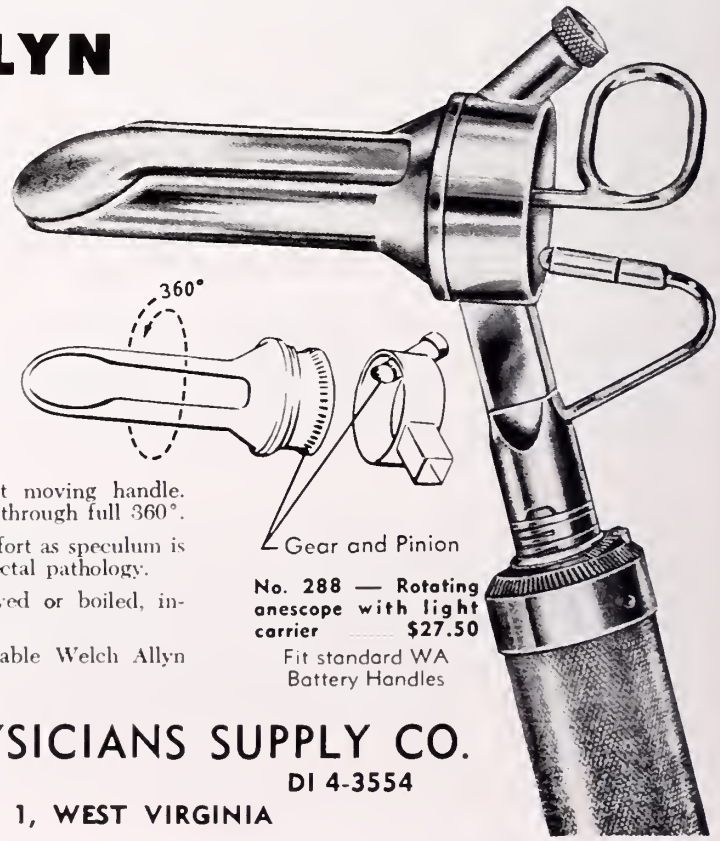


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After practicing in Hinton for a few years, he moved to Charleston and continued the practice of his specialty of obstetrics and gynecology in that city until his death.

At the time of his death, he was a member of Kanawha Medical Society, The West Virginia State Medical Association and the American Medical Association. While in Hinton, he served as secretary of the Summers County Medical Society, 1928-34.

Doctor Hudgins was also a Fellow of the International College of Surgeons, the World Medical Association, and the Medical Writer's Association. He was the author of numerous articles published in various professional journals.

Besides his widow, the former Marie Linville, he is survived by two sons, Lynn Douglas and Archibald Perrin, Jr., at home, and two sisters, Mrs. W. L. Foley of Greenwood, Virginia, and Mrs. L. H. Riley of Richmond.

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### MERWYN BLANCHARD MOORE, M. D.

Dr. Merwyn Blanchard Moore, 75, of Huntington, died in a hospital in that city on October 15, 1960.

Doctor Moore was born in Liberty, Mississippi, April 22, 1885. He received his M. D. degree from the Tulane University School of Medicine in 1912 and was licensed to practice in West Virginia in 1919.

He was a veteran of World War I, and an honorary member of the Cabell County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Besides his widow, he is survived by a daughter, Mrs. John W. Havens of Huntington; a son, Dr. M. B. Moore, Jr., of Columbia, Mississippi; two sisters and two brothers who reside in Mississippi, Mrs. L. W. Johnson of Columbia and Mrs. R. W. McCallister of Jackson, and Charles Moore of Liberty and Barnett Moore of Jackson.

* * * *

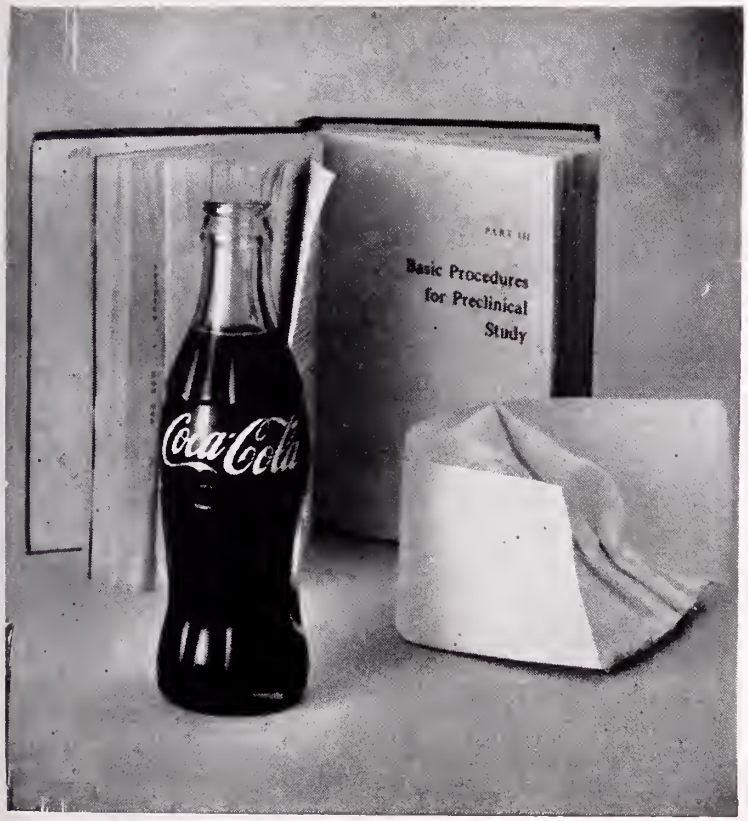
### HARRY KIGHT OWENS, M. D.

Dr. Harry Kight Owens, 91, of Elkins, died at his home in that city on October 19, 1960. Death followed a long illness.

Doctor Owens was born on September 18, 1869, at Bloomington, Maryland, son of the late William Meakins and Mary Ellen (Kight) Owens.

He attended Dickinson Seminary at Williamsport, Pennsylvania, Ohio Wesleyan University, Delaware, Ohio, and Bellevue Medical College in New York City. He received his M. D. degree from the Medical College of Physicians and Surgeons of Baltimore, Maryland, in 1895, and located for practice at Davis, in Randolph County. He moved to Elkins in 1906, where he continued in general practice until his retirement a few years ago.

From 1903 to 1906, Doctor Owens served as a Lieutenant in the Medical Corps of the West Virginia National Guard. In May 1917, he volunteered for service with the U. S. Army in World War I, and was commissioned a Captain. He had his basic training at Fort Benjamin Harrison in Indiana, where he remained until November, 1917, when he was transferred to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Camp Meade, Maryland, where he was in charge of one of the camp hospitals. He was released from the service with the rank of Major in February, 1919.

He was an honorary member of the Barbour-Randolph-Tucker Medical Society, the West Virginia State Medical Association and the American Medical Association. He had served as president and secretary-treasurer of his local society.

Doctor Owens is survived by a sister, Mrs. William A. Luke of Covington, Virginia. His wife died on August 9, 1959, following several months' illness.

* * * *

**BOYLSTON DANDRIDGE SMITH, M. D.**

Dr. Boylston Dandridge Smith, 70, of Man, died suddenly on October 29 while playing golf at a country club near that city. Death was attributed to a heart attack.

Doctor Smith was born at Opelika, Alabama, June 3, 1890. He received his M. D. degree from the University of Maryland School of Medicine in 1913 and interned at Maryland General Hospital. He had postgraduate work at the University of Bordeaux in France, and located in Logan County where he practiced medicine continuously until his death.

He served as Captain in the Medical Corps of the Army during World War I, and was stationed with a unit in France for nearly a year.

He was a member of the Logan County Medical Society, the West Virginia State Medical Association and the American Medical Association, and had served a term as president of his local society.

Besides his widow, he is survived by a son, Dr. Boylston Dandridge Smith, Jr., of Baltimore, and two daughters, Mrs. Ralph Cook of Man and Mrs. Charles Eades of Fort Benning, Georgia.

## Maintaining the American Way of Life

More than a century ago Alexis de Tocqueville reported: "These Americans are the most peculiar people in the world. You'll not believe it when I tell you how they behave. In a local community in their country, a citizen may conceive of some need which is not being met. What does he do? He goes across the street and discusses it with his neighbor. Then what happens? A committee comes into existence, and then the committee begins functioning on behalf of that need, and you won't believe this but it's true. All of this is done without reference to any bureaucrat. All of this is done by the private citizens on their own initiative . . . The health of a democratic society may be measured by the quality of functions performed by private citizens."

The heritage of the American way of life was established by our forefathers. Maintaining such a way of life requires the acceptance of responsibilities of citizenship and hard work by individuals. Osler called "work" the master word in medicine.—Lemuel C. McGee, M. D., in Delaware Medical Journal.

A great memory does not make a mind, any more than a dictionary is a piece of literature.—John Henry Newman.

# County Societies

### BARBOUR-RANDOLPH-TUCKER

Dr. Nicholas W. Fugo of Morgantown, professor of obstetrics and gynecology at the WVU School of Medicine, was the guest speaker before the regular monthly dinner meeting of the Barbour-Randolph-Tucker Medical Society at the Blackwater Lodge in Davis on October 20. His subject was "Prolonged Labor."

The speaker defined prolonged labor as that which lasts more than 24 hours, but emphasized the point that it is difficult to know exactly when labor begins. Using lantern slides, he discussed the causes of prolonged labor and methods of delivery. He recommended that fluids should be given, and that blood should always be available.

At the business meeting following the scientific program, Dr. William E. Christie, Jr., and Dr. Melvin C. Reinhard, Jr., both of Elkins, were elected to membership in the Society.

Dr. John L. Rittmeyer, vice president, presided at the meeting, and Dr. R. W. Cronlund introduced the speaker.—C. L. Leonard, M. D., Secretary.

* * * *

### CABELL

Dr. James A. Heckman of Huntington was named president elect of the Cabell County Medical Society at the regular monthly dinner meeting held in the Georgian Terrace of the Hotel Frederick in Huntington on October 13.

Dr. Jack Leckie was elected vice president and Dr. W. L. Neal and Dr. C. H. Boso were reelected secretary and treasurer, respectively.

Dr. William E. Bray, Jr. was elected a member of the board of censors to succeed Dr. W. D. Bourn. The hold-over members of the board are Drs. T. J. Holbrook and R. M. Bobbitt.

The new program for medical care for the aged was discussed by Dr. James S. Klumpp, who urged the Society to request the chairman of the Council to call a meeting of that group to consider the whole problem of medical care of the aged under the provisions of the act passed at the recent session of the Legislature.

It was agreed that a letter outlining the views of the members of the Society be mailed to Dr. John W. Hash and that copies be sent to the secretaries of the other component societies.

Dr. L. B. Gang presented an interesting report concerning the Huntington Clinical Foundation, which recently established a medical student loan fund which authorizes a loan up to $1,000 a year to junior and senior medical students who are residents of West Virginia or adjacent states, or who are enrolled in the WVU School of Medicine and are in the upper half of their classes. (Ed: A news story concerning the loan fund appeared in the November issue of *The West Virginia Medical Journal*). Doctor Gang also discussed the affairs of the


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ELIZABETH B. PARSONS, *Cliaical Psychologist*

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medical social service agency and expressed the hope that the Society would lend its support to that group.—W. L. Neal, M. D., Secretary.

* * * *

### LOGAN

Representatives of the Disability Section of the Social Security Administration presented the scientific program at the regular monthly meeting of the Logan County Medical Society which was held in Logan on November 9.

Dr. Florence Hampton, Medical Consultant to the Vocational Rehabilitation Division of the Social Security Administration, presented a most interesting talk on the general subject of disability. A film, "The Disability Decision," was shown following her address.

Dr. R. M. Kessel, the president, presided at the meeting.—Luke Combs, M. D., Secretary.

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### McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held at the residence of Dr. and Mrs. A. J. Villani in Welch on Wednesday evening, October 12.

The following resolution concerning the death of Dr. H. T. Schiefelbein of Welch was offered by Dr. J. Howard Anderson and adopted unanimously:

WHEREAS, The untimely and tragic passing of Harry Theodore Schiefelbein brought a profound surge of sorrow into the hearts of each and every one of his associates in the Healing Art; and,

WHEREAS, We recall with pride the many years of sacrificial service he has rendered to humanity in relieving suffering and rehabilitating their grievous handicaps; and,

WHEREAS, We feel that his sincere, loyal and enthusiastic devotion to his professional duties and his contribution to the welfare of his patients and the community at large were a continual inspiration to all of us; and,

WHEREAS, We, who knew him best, cherish in our hearts our association with him because of his genial personality, his integrity of character and the superlative high standards he set for himself in the practice of his profession:

THEREFORE, BE IT RESOLVED BY THE McDOWELL COUNTY MEDICAL SOCIETY, in official meeting assembled, that we express to his bereaved widow and daughters our deepest sympathy and beg to be permitted to share with them their great loss; and,

BE IT FURTHER RESOLVED, That a copy of these Resolutions be spread upon the minutes of the McDowell County Medical Society, and copies sent to his family and to *The West Virginia Medical Journal.*

Dr. J. Howard Anderson, chairman of the medical economics committee, read a resolution expressing the desire of the members of the Society that the program for medical care of the aged be removed from under the control of the Department of Public Assistance.

The committee was directed to draft a resolution and submit it to the State Medical Association, protesting the present low levels of DPA professional fees and requesting that there be an increase in fees.


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The following nominating committee was appointed with instructions to report at the next meeting: Dr. Ray E. Burger, chairman, and Drs. F. L. Johnston and J. Howard Anderson.

The president, Dr. Guy E. Irvin, presided at the meeting, which was attended by 17 members and one guest.—George L. Fisher, M. D., Secretary.

* * * *

**MONONGALIA**

Dr. Edmund B. Flink, professor of medicine at the WVU School of Medicine, was the guest speaker before the regular monthly meeting of the Monongalia County Medical Society held at the Hotel Morgan in Morgantown on November 1. He spoke on the subject of "Salt and Water."

The Society approved the application of Dr. D. Franklin Milam, member of the staff of WVU School of Medicine, for membership by transfer from the Kanawha Medical Society.—C. A. Logue, M. D., Secretary.

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**OHIO**

Dr. S. S. Bobes of Wheeling was installed as president of the Ohio County Medical Society at the October meeting. He succeeds Dr. L. A. Lyon.

The Society approved the appointment of Drs. James Arbaugh, C. H. Hile and A. S. Daniels as members of the board of trustees of the West Virginia Hospital Services, Inc.

The new board of censors and grievance committee is composed of Dr. E. S. Phillips, chairman; and Drs. W. C. D. McCuskey, W. J. Steger, R. J. Reed and D. E. Greeneltch. Dr. Michael Caruso's application for membership in the Society was approved, and Dr. Bradford M. McCuskey was accepted as a member by transfer from the Philadelphia County Medical Society.

A letter was read from the Cabell County Medical Society, expressing concern over recent legislation dealing with medical aid for the aged. The Society agreed with the contention of the Cabell Society, and a committee was appointed to give the matter attention.

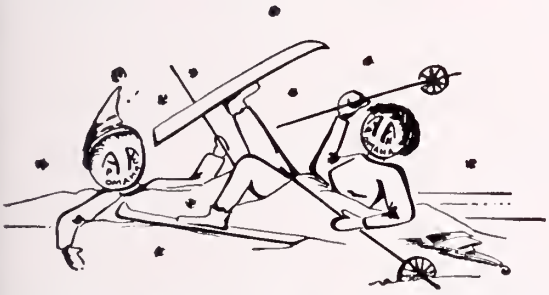
A standard insurance form to be used by physicians for all insurance companies was adopted by the Society. The form is the one approved by the health insurance council and the AMA Council on Medical Services.—William H. Hagedorn, Jr., Executive Secretary.

## Sinus Disease in Children

The incidence of sinusitis in children cannot be accurately stated in exact percentages because of many variations in environmental influences. Such factors as the manner of living, the climate, the housing, feeding, injudicious clothing and the care which parents may give or neglect to give all contribute to the etiology of the disease.

It is easily understood that the more unfavorable the above factors are the greater will be the incidence of sinusitis. It is also very evident that the underlying predisposing factor in all cases is the common cold which is forever prevalent among all classes of society.

The frequency of the disease is greater during the inclement weather months especially in colder sections of our country. During the winter months, the resistence of the child is naturally lower because of the lack of sunshine and the constant exposure to chilling. It is a recognized physiological fact that chilling of the feet rapidly lowers body temperature and in so doing causes the nasal mucosa to swell with subsequent stasis within the sinuses. This situation rapidly enhances the growth of organisms within the sinus cavities.—James E. Povlin, M. D., in Journal, Maine Medical Association.

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*Fourth Vice President:* Mrs. Earl S. Phillips, Wheeling
*Treasurer:* Mrs. Andrew J. Weaver, Clarksburg
*Recording Secretary:* Mrs. Rupert W. Powell, Fairmont
*Corresponding Secretary:* Mrs. C. A. Smith, Morgantown
*Parliamentarian:* Mrs. Claude R. Davisson, Weston

### EASTERN PANHANDLE

Members of the Woman's Auxiliary to the Eastern Panhandle Medical Society entertained the wives of physicians who attended the Fifth Annual Potomac-Shenandoah Valley Postgraduate Institute which was held in Martinsburg, October 21-23.

Mrs. F. A. Hamilton, Jr., was general chairman of the entertainment committee and Mrs. E. Andrew Zepp served as co-chairman. Auxiliary members also were in charge of the general registration desk for the meeting.

There were several tours arranged for the wives during the three-day meeting, including visits to Hagerstown, Maryland, Antietam battlefield and Shepherdstown. Also visited were historical Washington homes in and near Charles Town and Harpers Ferry, and several glass and furniture factories.

Luncheons were held at the Martinsburg Country Club on Friday and Saturday, October 21-22, and bridge parties were held during the afternoons.

Several meetings were held prior to the Institute to coordinate plans for the entertainment program. Mrs. C. V. Townsend, the president, presided at the meetings.—Mrs. L. Walter Fix, Recording Secretary.

* * * *

### HARRISON

Dr. J. J. Oleson of Maywood, New Jersey, and Dr. James H. Getzen of Charleston, were guest speakers before a joint dinner meeting of the Harrison County Medical Society and Auxiliary at the Stonewall Jackson Hotel in Clarksburg on November 3.

Doctor Oleson is a member of the staff of the John L. Smith Memorial for Cancer Research, Charles Pfizer & Co., Inc. His subject was "Cancer Chemotherapy—Search and Research."

Doctor Getzen, a member of the staff of Memorial Hospital in Charleston, presented several cases, explaining the treatment used, and the results obtained. Both speakers used slides to illustrate their papers.

Dr. Richard V. Lynch, Jr., president of the Society, presided at the meeting. Besides members of the Society and Auxiliary, the meeting was attended by members of the board of directors of the Harrison County Cancer Society, and local and district representatives of


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* * * *

### MINGO

A "Coffee Meeting" of the Woman's Auxiliary to the Mingo County Medical Society was held at the home of Dr. and Mrs. Clarence G. Rayburn in Forest Hills, Kentucky, on October 27.

At the business meeting which preceded the social activities it was announced that Mrs. Don V. Hatton had been accepted as a new member.

Reports were received and plans agreed upon for future activities. One of the features of the meeting was a round table discussion of worthwhile projects that will be undertaken during the current Auxiliary year.

It was announced that subscriptions of the Mingo Auxiliary to the Bulletin of the Woman's Auxiliary to the AMA will reach 100 per cent this year.

The sum of $15 was pledged for the American Medical Education Foundation.

It was decided that a free-will donation would be made at the December meeting to benefit the "Clothes Closet," a local organization designed to help needy school children of the Mingo County area.

The president, Mrs. W. H. Price, presided at the meeting which was attended by 18 members.—Mrs. Robert J. Tchou, Correspondent.

### PARKERSBURG ACADEMY OF MEDICINE

More than 150 physicians, their wives and children attended an outing held at the farm of Dr. and Mrs. Faye Greene, near Williamstown, on October 1. The affair was the first activity of the fall season sponsored by the Woman's Auxiliary to the Parkersburg Academy of Medicine.

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The annual dues tea of the Woman's Auxiliary was held at the home of Dr. and Mrs. David B. Thornburgh in Parkersburg on October 11. Mrs. Charles H. Barnett, the president, presided at the meeting which was attended by more than 50 members and guests.

Honored during the meeting were the charter members of the Auxiliary. It was pointed out that the first meeting of the group was held on May 14, 1926.

A report was presented concerning the recreational fund for student nurses at St. Joseph's and Camden-Clark hospitals, which is the service project for the Auxiliary.

Hostesses for the meeting were Mesdames Lyle D. Vincent, Paul L. McCuskey, Robert C. Lincicome and Donald R. Lantz.—Mrs. David B. Thornburgh, Chairman, Press and Publicity.

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I've never met a healthy person who worried much about his health, or a good person who worried much about his soul.—John B. S. Haldane.


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# Book Reviews

**THE MANAGEMENT OF FRACTURES AND SOFT TISSUE INJURIES—By the Committee on Trauma, American College of Surgeons. Based on an Outline of the Treatment of Fractures (Seventh Edition), and Early Care of Acute Soft Tissue Injuries (Second Edition). Pp. 372, with illustrations. Philadelphia and London: W. B. Saunders and Company. 1960. Price $5.00.**

This is a manual on the treatment of fractures and the care of acute soft tissue injuries. Formerly the contents of this book were published in two volumes. It has now been combined to form a single handbook which gives in quite brief but still adequate statements the necessary information which the physician needs to initiate treatment of most of the common injuries. It is the work of many surgeons.

While the Committee on Trauma of the American College of Surgeons was responsible for compiling the major portion of the content of this book, other committees and other surgeons were called upon to give their opinions on controversial matters. Various authorities were asked to write or rewrite certain sections in which progress has changed some formerly held surgical concepts. Part II, which deals with soft tissue injuries, has been entirely rewritten.

The material is presented in a forceful and clear manner. The illustrations are simple and adequate. The statements are frequently dogmatic but no more so than is desirable in an outline of diagnosis and treatment such as this one. The discussion of the principles of prophylaxis against tetanus is especially good and reflects the changing ideas of the surgeons who form the Subcommittee on Prophylaxis Against Tetanus of the Committee on Trauma of the American College of Surgeons.

The book is one which should be on the book shelf of every emergency room and should be available to every physician who treats trauma. It can be recommended especially to medical students, interns and surgical residents. The practicing physician will find it most helpful for quickly checking his own methods of therapy against current surgical thought as outlined by the authorities who have written this manual.—Hu C. Myers, M. D.

* * * *

**MEDICINE TODAY—By Marquerite Clark, Medical Editor of Newsweek. Pp. 360. Funk and Wagnalls Company, New York City. 1960. Price $4.95.**

The author is well known in her position as Medical Editor of the magazine, *Newsweek*. She is perhaps one of the best informed lay persons in the matter of the solution of medical problems. Her editorial efforts have demonstrated her intense interest in, and the transmittal to the general public of pertinent information regarding the complex advances in medical research, all of which is presented simply and effectively in a manner interesting both to the layman and the scientist.

The truth of this statement is aptly demonstrated in her recent book. She has described in a readable and understandable manner the progress of medicine during the past decade. Her subjects include heart dis-

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ease, cancer, mental health, psychosomatic disorders, arthritis, virus infection, gynecological conditions, pediatrics, and yes, even the consideration of diets and weight control measures.

Your reviewer congratulates the author upon the simplicity and scope of her writings and recommends her book wholeheartedly to both the laity and the medical profession. The reading and consideration of its contents will indeed be time well spent.—James S. Klumpp, M. D.

* * * *

**YOUR CHILD'S CARE—By Harry R. Litchfield, M. D., Director, Department of Pediatrics and Baby Care Clinics, Brooklyn Womens Hospital, and Leo H. Dembo, M. D., Assistant Clinical Professor of Pediatrics, Western Reserve University School of Medicine, Cleveland. Pp. 257. Doubleday & Company, Inc., 575 Madison Avenue, New York 22, N. Y. 1960. Price $3.95.**

Although this book has some good sections, it is far from meeting the claim advertised on the dust cover: "Newly revised and enlarged, this rewarding volume will prove indispensable to every mother."

It must be conceded that practicing the art of medicine allows for a bit of latitude; however, it does seem somewhat unusual to note the authors' repeated recommendation of boric acid and the statement that all-wool garments next to the skin are to be preferred. Granting the authors' right to prefer certain drugs, it seems somewhat out of place to mention these repeatedly by brand names, e.g. petroleum jelly or petrolatum is always mentioned by its popular trade name.

There are some statements which appear too absolute for safe generalization. For instance, saying "Their results are invariably excellent" in reference to therapy for speech disorders is rather optimistic. Also it seems rather hazardous to make this unqualified statement in reference to anti-tetanus serum: "He won't develop any reaction after the first injection."

Another criticism is that the book is rather foggy in places. For example, on page 96 the question is asked, "How frequently does nephrosis occur in children?" Answer: "It is more frequent in young children than in adults. Infants as young as two months and children up to 16 years have been found to have the disease." This obviously does not answer the question. Similar examples of haziness are found elsewhere, such as this one on page 203: "Would you say that putting a child in a closet or locked room is really effective discipline?" Answer: "Punishing a child by placing him in a closet or locking him in his room is neither effective nor desirable. If you feel that you must discipline the child in this way allow him to remain in the room, but pay no attention to him. Since the child relies on companionship a great deal (younger children don't know how to play alone as well as older children do) he will be abject and miserable until he can come back into your good graces."

It might be nice to know what the authors mean in this answer on page 95, where they are discussing cystic fibrosis of the pancreas: Question: "How often does it occur?" Answer: "It has been estimated that one child in every 600-1000 children is born with a


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congenital pancreatic deficiency. Also, one out of every 15 children, in some form, may be affected by this disease."

It is somewhat difficult to reconcile some of the answers with one another. For instance, on page 75 it is stated, "Loss of appetite and refusal of food is always a matter of concern," while on page 76 it is stated, "Toddlers and pre-school children seldom manifest any desire to eat. This is a general pattern and is no cause for worry."

Many questions are answered in a manner which most physicians would consider acceptable, and there are some very good sections such as the one beginning on page 176 concerning accident prevention, and the section on the Rh factor which begins on page 184; nonetheless, the faults are so numerous that it is not possible for me to recommend this book.—Donald M. Burke, M. D.

* * * *

**"FUNDAMENTALS OF CHEST ROENTGENOLOGY."—By Benjamin Felson, M. D., Professor and Director, Department of Radiology, University of Cincinnati College of Medicine; Director of the Department of Radiology at several Cincinnati Hospitals; Special Consultant to the USPHS; and Consultant to the Dayton and Cincinnati VA Hospitals. Pp. 301, with 450 illustrations on 238 figures. Philadelphia & London: W. B. Saunders Company. 1960. Price $10.00.**

This book by one of the masters of the art is a call back to the fundamentals. It attempts to provide the reader with the working tools with which to assay a diagnosis based upon reasoning and judgment. It makes one think. That, of course, is the object of the author who is distressed to see so many attempt diagnosis from x-ray films without thinking but by merely attempting a memory exercise "Where have I seen something like that before?"

The basic principles of chest roentgenology are well presented. Unless this approach by way of the basic principles is employed, the x-ray examination must often be in vain.

The anatomy and related physiology of the lungs is stressed and the deviations from the normal noted. Special signs are given and finally a tabulation of the findings in 18,000 "normal" chest roentgenograms. The text is well written and numerous touches of humor add to the readability and help to fix the concepts in the minds of the readers. The illustrations are excellent photographic reproductions of roentgenograms, technically well done and well chosen to illustrate the points which the author makes.

This book will be especially valuable to students. For all those for whom radiology is a part of the practice of medicine, it will strike a responsive cord. We are happy to recommend it.—Karl J. Myers, M. D.

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The mark of the immature man is that he wants to die nobly for a cause, while the mark of a mature man is that he wants to live humbly for one.—Wilhelm Stekel.


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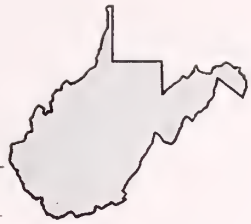

January 1960 Vol. 56, No. 1

## Premenstrual Tension Syndrome And Primary Dysmenorrhea*†

*Eduard Eichner, M. D.*

Dysmenorrhea and the premenstrual tension syndrome (PTS) are full-fledged members of that group of psychosomatic diseases associated with the menstrual cycle. Each has a marked psychic overlay, but also has associated physical disabilities of varying degree. Unfortunately, there is no base line and no method of getting adequate controls in either group.

The premenstrual tension syndrome includes symptoms which in some patients persist throughout the month, may occur in the absence of ovulation, and even may extend beyond the clinical climacteric. It is this variation in symptoms and in reports which make clinical comparisons unsatisfactory. There is as little agreement in considerations of the cause of this syndrome as there is in its diagnosis or treatment. These have been reviewed.[4, 5] In an attempt to exclude a major variable, almost all patients in our series had one thing in common: there was a rather abrupt release of tension with the onset of the flow.

Excess autogenous estrogens were considered originally as the cause, and treatment consisted of cartharsis and diuresis. As other ovarian steroids were identified, each in turn was named the responsible toxin. Later investigators disagreed as to whether or not excess amounts, inadequate amounts or mere imbalances were the primary etiologic factors. When these failed to account for the symptoms, other causes of salt retention were sought. The pituitary antidiuretic hormone was next considered. Adequate diuresis, however, does not cure nor prevent this disability.

*From the Division of Obstetrics and Gynecology, Mount Sinai Hospital, Cleveland, Ohio.

†Presented before the Seventh Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice at Charleston, W. Va., June 21, 1959.

Submitted to the Publication Committee, July 5, 1959.

### *The Author*

- **Eduard Eichner, M. D., 10605 Chester Avenue, Cleveland 6, Ohio.**

Hypoglycemia was identified in some patients, and hyperinsulinism was considered causal. A simple neurovegetative approach also has given clinical satisfaction.

Our investigation started with questionnaires to groups of symptomatic patients. Student nurse controls received the same questionnaire. These listed as possible symptoms almost all those previously described in the literature. In all cases the answers could be modified by the type or method of question used. When patients with premenstrual tension syndrome sought relief, approximately half had emotional symptoms as their primary complaint. Only one-fifth complained of congestion. In responding to the questionnaire, however, three-fourths admitted symptoms associated with congestion, symptoms which for the most part were accepted without difficulty, and which tended to be ignored.

The responses of the nurse controls were almost identical, but less than 10 per cent of those with symptoms thought their condition grave enough to warrant treatment. Even those accepting treatment were not constant in attendance. On the other hand, private patients were anxious to accept any hope for relief. Many were not primarily aware of their difficulties, but husbands and co-workers were able to bring the point home. These often underscored the inharmonious interpersonal relations and the many domestic tragedies which resulted from premenstrual tension syndrome. In our control group of student

nurses, 70 per cent experienced symptoms of premenstrual tension syndrome, ample evidence that women in general experience these symptoms with the same lack of understanding.

Bickers and Woods,[1] as well as Billig,[2] have written on industrial losses associated with impaired efficiency secondary to premenstrual tension syndrome. Pollack [12] has reported unpremeditated criminal acts performed by women during the premenstrual period. Morton[10] demonstrated that behavioral problems in institutionalized patients could be ameliorated by treatment. Perr[11] has written on the legal and psychiatric aspects of premenstrual tension. These authors stress that premenstrual tension deserves adequate treatment because of its social and industrial implications.

For success, the primary complaint must be treated adequately. Should the physician select his patient only from the group with congestive symptoms, any nontoxic diuretic will effect an excellent response. Should the therapist be interested only in patients with pain, analgesics will be successful. Should the practitioner be inclined toward the psyche, any proper "normalizer" will work. But should he be interested in a patient as a whole, and these patients need that kind of a doctor, much more than any one of the preceding remedies will be needed. The etiologic agent in this complex has not yet been discovered. This is not surprising in view of the complexity of the symptom pattern and the variability in reported therapeutic response. The literature is replete with successful treatment by estrogens, progestins and combinations of these. Since water retention is frequently present, overresponsiveness to or overactivity of endogenous antidiuretic substance has been suggested, as well as an allergic response to the sex steroids. Changes in or modifications of the pituitary-adrenal-ovarian axis has been suspected but, as with all other theories, conclusive proof still is lacking. The same is true for the remaining catch-all, autonomic imbalance. It is probable, however, that somewhere along the endocrine axis which involves the hypothalamus and the autonomic

NAME: _____

DATE: _____

| DAY OF CYCLE | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | *** | 25 | 26 | 27 | 28 | 29 | 30 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BREAST TENDERNESS | | | | | | | | | | *** | | | | | | |
| BREAST SWELLING | | | | | | | | | | *** | | | | | | |
| INTESTINAL BLOATING | | | | | | | | | | *** | | | | | | |
| LOW BACKACHE | | | | | | | | | | *** | | | | | | |
| CRAMPS | | | | | | | | | | *** | | | | | | |
| SWELLING OF ANKLES | | | | | | | | | | *** | | | | | | |
| HEADACHE | | | | | | | | | | *** | | | | | | |
| INSOMNIA | | | | | | | | | | *** | | | | | | |
| IRRITABILITY | | | | | | | | | | *** | | | | | | |
| DEPRESSION | | | | | | | | | | *** | | | | | | |
| FEELING OF ANXIETY | | | | | | | | | | *** | | | | | | |
| CRYING SPELLS | | | | | | | | | | *** | | | | | | |
| EXCITABILITY | | | | | | | | | | *** | | | | | | |
| | | | | | | | | | | *** | | | | | | |
| | | | | | | | | | | *** | | | | | | |
| WEIGHT IN POUNDS | | | | | | | | | | *** | | | | | | |
| MENSTRUAL FLOW | | | | | | | | | | *** | | | | | | |
| TREATMENT SCHEDULE | | | | | | | | | | *** | | | | | | |
| | | | | | | | | | | *** | | | | | | |

INSTRUCTIONS:

Record daily in the appropriate columns such symptoms as you experience. Please use the following code to enter each of these :

0 - NO SYMPTOMS AT ALL

1 - VERY SLIGHT SYMPTOMS

2 - MILD SYMPTOMS

3 - MODERATELY SEVERE SYMPTOMS

4 - VERY SEVERE SYMPTOMS

ALSO, WEIGH YOURSELF EACH MORNING ACCORDING TO INSTRUCTIONS, AND RECORD.

INDICATE THE DAYS OF YOUR MENSTRUAL FLOW BY CHECK ( ) MARKS.

* * * * * * * * * * * * * *

**Figure 1**

nervous system will someday be found the cause of premenstrual tension.

We account for the great variety of symptoms as part of the neurovegetative complex, as with each patient it is "to each his own." This also may explain the variable responses and successes to all therapies, as well as the large number who become asymptomatic when understanding by either the patient or her attendant is achieved. This is very evident when the patient is aware that treatment can give adequate relief.

Our original group of 87 patients has expanded to over 350 who have been studied. Treatment has included diet, diuresis, stimulants, steroids, tranquilizers and various combinations of these. Originally, each patient was placed on a high protein, low sodium (200 mg./day) diet, and was asked to fill out a premenstrual tension diary (Figure 1) in the interval preceding her next visit. This occurs approximately one month later when the diary is complete for one full cycle. At this visit the diary, the patient's symptoms and her response to diet are discussed and evaluated. She is constantly reassured, and she is assured that ample relief is obtainable by one of several available methods of treatment. The fact that an attempt will be made to fit the proper treatment to her rather than to fit her to any standard treatment is stressed at the time of each visit.

Patients with adequate responses to diet alone are not otherwise treated. Maintenance of the strict diet varied from "all month" to "with symptoms," according to the patient's needs. During the first month dietary treatment was started not later than the 15th day of the cycle. Failures on diet were then placed on one of the diuretics, and were asked to continue their dietary restrictions. In the early days of the study diuretic therapy was begun about 10 days before the expected onset of flow. Because of menstrual irregularities and occasional adverse side-effects, treatment is now withheld until symptoms develop. It is discontinued with relief. This has the added advantage of accentuating relief when obtained. Invariably weight loss was adequate, but the overall response was not as satisfactory. The greatest weight loss was almost 13 pounds, and one subject with over 10 pounds loss retained her tension headache even though bloating and breast congestion were minimized. Enteric coated tablets of ammonium chloride reached the anal canal intact in several patients. Additional groups were treated with the newer nonmercurial diuretics, but there seemed to be a very great variability in the patient-dose-response curve, and all lost their effectiveness when given too early or for too prolonged a period. With these, apparently adequate diuresis failed to relieve all the symptoms even though congestion disappeared. The latest of these (chlorthiazide and hydrochlorthiazide) are now being studied and may be the exception (Chart 1).

The fact that congestion was not a primary complaint in the majority of patients treated may explain why adequate dehydration by diuresis did not give satisfactory results.

Those obtaining relief on any regimen were kept on that particular course of treatment unless toxic side-effects warranted discontinuation of therapy. Failures, or successes with undesirable side-effects were placed on multidimensional tablets (Pre-Mens®) containing caffeine, homa-

**CHART 1**

**DIURETIC TREATMENT FOR PREMENSTRUAL TENSION**

| *Rx* | *Dosage* | *No. Patients* | *Satisfactory Results* | *Ill Effects* |
|---|---|---|---|---|
| Acetazolamide (Diamox®) | 0.125 - 1.0 Gm. Daily to Relief, Start with Symptoms | 62 | 33.9 | 12.9 |
| Ammonium Chloride, Plain-coated | 4.0 Gm. Q.I.D. for 4 Days, Start with Symptoms | 38 | 28.9 | 13.1 |
| Hg - Theophylline Cmpd: | | | | |
| (Cumertilin® Inject.) | 1 - 2 cc. Intragluteal, Once at Onset | 15 | 40.0 | 6.7 |
| (Cumertilin® Oral Tab.) | 2 Tabs. Q. AM to Relief, Start with Symptoms | 30 | 26.6 | 10.0 |
| Aminometramide (Mictine®) | 1 Tab. Q.I.D. 3 Days (less is inadequate) | 5 | 20.0 | 60.0 |
| Aminoisometradine (Rolicton®) | 1 Tab. Q.I.D. 2 Days, Then 1 Tab. B.I.D. 15th Day Cycle to Onset of Flow | 23 | 39.1 | 8.7 |
| Ethoxzolamide (Cardrase®) | 62.5 - 250 Mg. Daily 3 Days Starting with Onset of Symptoms | 5 | 40.0 | 40.0 |
| | 62.5 - 250 Mg. Q.2.D. Starting 18th D. | 9 | 33.3 | 22.2 |
| Hydrochlorothiazide (Hydrodiuril®) | 1 Tab. B.I.D. 15th Day to Onset of Flow, or Duration Symptoms | 7 | 57.2 | 28.6 |
| Total of Diuretics: | | 194 | 33.5 | 14.4 |

tropine and B-complex, with ammonium chloride as the diuretic. Some patients received this tablet with added amphetamine, some with reserpine. Others received identical looking placebos. The therapeutic tablet gave most consistently good results in our hands. Medication was started when symptoms occurred and was discontinued with relief, or in five days, whichever came first. If relief during the specified period was not present, treatment was considered a failure on the first course. Treatment was not considered successful, however, unless it had worked adequately for at least three consecutive cycles. The low salt diet was used concomitantly.

Despite a relative diminution in the diuretic response, the addition of reserpine moderately intensified the relief in some patients. Substituting amphetamine for reserpine seemed to accentuate the irritability and insomnia without improving the overall response. There was a small group, however, who required amphetamine for relief of the severe depression associated with their tension complex. In the countries "south of the border" amphetamine is considered a prime necessity in the treatment of premenstrual tension, again demonstrating the versatility of the disease. In England and the Low Countries, ethisterone is the treatment of choice.

In general we have eschewed the use of steroids lest we upset the cycle of an already disturbed patient. Lately several synthetic progestogens were made available for use in PTS as well as in dysmenorrhea. The results have not been as satisfactory as those achieved by multidimensional therapy. One of these, "norethynodrel," produces typical congestion symptoms in some patients. The two new polyvalent products have been tried. The first contains in varying strengths acetazolamide and tridihexethyl iodide with atropine and hyoscine in immediate and sustained release capsules. The second consists of ethisterone, bromotheophylline, chlorprophenpyridamine, salicylamide, caffeine and pherphenazine. The latter has not been as successful as the European reports on ethisterone would lead one to expect. The other has been satisfactory, but over-sedative effects as well as numbness secondary to the acetazolamide have been present. This is the reason for the experimental variation in strengths of the drug per capsule. All of these have had an effectiveness exceeding that of adequate diuresis, however, again demonstrating the protean aspects of premenstrual tension (Chart 2).

Most failures were evident within the first month of treatment. Successfully treated patients immediately recognized the placebo by its absence of effect. Others, offered the placebo first, frequently had initial good results. These usually downgraded rapidly to poor results within three to four months. In all probability the original good response was caused by our assurance that benefit could be obtained. It is this effect which

**CHART 2**

**TREATMENT OF PREMENSTRUAL TENSION**

| *Rx* | *Dosage* | *No. Patients* | *Satisfactory Results* | *Ill Effects* |
|---|---|---|---|---|
| DIET: — Hi-Protein, Lo Sodium | (200 Mg. Na Daily) Starting 15th Day of Cycle | 347 | 15.3 | 0.0% |
| ALL DIURETICS | Variable — See Chart 1 | 194 | 33.5 | 14.4 |
| POLYPHARMACAL MEDICATION: | | | | |
| Premens® Plain | Schedule Constant for All Types | 242 | 84.3 | 5.0 |
| Premens with Amphetamine® | 2 Tab. T.I.D. Starting with Symptoms. | 28 | 64.3 | 42.8 |
| Premens with Reserpine | Discontinue with Relief or in 5 Days. | 121 | 81.0 | 6.6 |
| Placebo Control | Restart SOS c Symptoms. | 45 | 8.8 | 11.1 |
| Diamox Compound* "A", "B", "C" | 1 - 2 Caps. Daily Starting 7 - 10 Days Before Expected Onset of Flow | 26 | 61.5 | 24.6 |
| Ethisterone Compound* | 1 - 2 Tabs. Daily Starting 7 - 10 Days Before Expected Onset of Flow | 14 | 57.1 | 42.8 |
| SYNTHETIC STEROIDS | | | | |
| Ethisterone Compound | See Polypharmacal Medication—Ill Effects Primarily Heavy or Prolonged Bleeding | | | |
| Delalutin® | 250 - 375 Mg. I.M. 15th - 18th Day Cycle | 9 | 22.2 | 22.2 |
| Enovid® | 1 Tab. 5th thru 25th Day Cycle, *or* | 7 | 42.9 | 28.6 |
| | 1 - 2 Tabs. Daily 15th - 25th Day Cycle | 10 | 50.0 | 40.0 |
| Braxorone | 2 - 6 Tabs. Daily 5th thru 25th Day | 5 | 20.0 | 40.0 |
| | 2 - 6 Tabs. Daily 15th - 25th Day Cycle | 6 | 50.0 | 33.3 |

*Series incomplete

makes analysis of results so difficult. Almost all patients can be fooled briefly, but few remain so. Regardless of the medication used, there was a decreased need for therapy when the treatment was successful. The patient had to be convinced that relief was available at any time should she require it. In fact many required no treatment after the first few months, secure in the knowledge that their effective medication was available in the medicine chest for immediate use should the necessity ever arise. This diminishing need was least evident in those patients most troubled by symptoms associated with edema.

After discussing the broad, ill defined vistas of the premenstrual tension syndrome, that of dysmenorrhea seems simple by comparison. Yet this offers a greater challenge primarily because patients do recognize dysmenorrhea, and many girls and women do attempt to take advantage of the general knowledge that the human female may have dysmenorrhea. Semantically this means a "difficult" period, and by usage a painful one. Since pain is subjective, and "subjective" is defined as "existing in the mind," all dysmenorrhea must have a psychic component and even may be psychogenic in origin. For simplicity, however, this discussion will be limited to primary or functional dysmenorrhea. Occasionally, "primary" dysmenorrhea becomes "secondary" after an adequate workup. Dysmenorrhea, however, associated with gynecic neoplasms, infections, inflammations, malpositions or displacements, hypoplasia, cervical or vaginal atresia or stenosis, endometriosis, and the like, will not be discussed.

Despite the apparent psychic impact on dysmenorrhea, Golub[6] and his associates concluded that dysmenorrhea cannot be cured by psychologic suggestions as employed by them. In a survey of secondary schools in Philadelphia, approximately 20 per cent of teen-agers were spontaneously cured while in a slightly smaller group dysmenorrhea developed during the study. It is possible that the onset of ovulation was responsible for the development of this condition in the second group, as many now consider that true primary dysmenorrhea occurs only in the presence of ovulation. It is also possible that dysmenorrhea in the first group disappeared with knowledge, as apprehension faded simultaneously.

The physician must take a complete history at the first visit, and should do a thorough physical examination as soon as feasible. Rectal examination should be included, and must be done if the introitus is not marital. This part of the examination may be delayed one or two visits, or until there is greater rapport between the patient and her doctor. At no time should the patient be aware that her physician is undecided as to the nature of her condition. He must assure her that relief is immediately obtainable, and that cure is possible well within the not too distant future. For this reason the next period should be pain free if possible. If time is short, medication for relief of pain must be given. If adequate time is available, ovulation should be inhibited by oral estrogens or the newer progestogens. In regard to the various analgesics, it is well to remember that some patients are nauseated by codeine, that Percodan® produces dizziness and weakness and that meperidine is habit forming. The newer non-narcotic analgesics are inconstant in their effect, so that ample medication should be given the first time. Later this may be decreased as indicated. Benectin® has been of great value in preventing or minimizing discomfort when given twice daily for several days preceding the flow. A small group of patients with premenstrual tension and dysmenorrhea are frequently relieved of the latter by relief of the former, either by diuretic or multiphasic (Pre-Mens®) therapy.

If possible, gynecic disease should be ruled out at the first examination. At times examination under anesthesia is required, but this may on occasion be deferred or dismissed. The cervico-uterine canal should be sounded to rule out obstruction, and to determine the relative cervico-corporeal lengths. Vaginal spreads and basal body temperature curves will confirm ovulation. Seldom do endocrinopathies *per se* have a specific relation to the onset or cure of dysmenorrhea. When the patient's confidence has been gained, and when she knows that relief is obtainable, then the diagnostic survey may be continued. Anemia and avitaminosis should be overcome.

Through clinical experience we have learned that dysmenorrhea frequently is aggravated by pelvic congestion, by lowered tolerance to pain, by vigorous exertion or prolonged standing, and by excessive nervous or emotional fatigue. These last factors may be so prominent that too great a psychic implication may be inferred by the examiner, as he fails to appreciate the emotionally degenerating effects of expected and recurrent pain. Nonspecific treatment, therefore, necessitates that these girls should lead a relatively quiet, healthful and harmonious life. Superficial psychiatric assistance and psychotherapy by the attending doctor require understanding so that the patient can appreciate her own problems.

Discussion thus far has considered all patients with primary dysmenorrhea as being alike. Such

is not the case. In some the pain disappears with the onset of the flow, in others it first comes at this time. Some have mixtures of the above. Oftentimes we have assumed tissue swelling, myometrial ischemia or spasm as direct causes. Yet Diehl and Hundley[3] found motility normal. Relaxant type products have been tried with inconstant success, yet antispasmodics play a great role in the relief of symptoms. Except for its aspect in human morality, alcohol still is one of the best uterine antispasmodics. This, or its psychic effects, accounts for great past successes of Lydia Pinkham remedy. Other antispasmodic drugs include the belladonna series (atropine, hyoscine, papaverine), anticholinergic drugs (Banthine®, Bentyl®, Prantal®), phenothiazine (Phenergan®, Trilafon®,) mephenesin, benzyl benzoate and some of the newer sympathomimetic drugs. These should be used for several days preceding the expected flow.

Although the amphetamines belong in the adrenergic group, their primary effect is to elevate the patient's mood so that she is not disturbed by pain. Recently, however, codeine has been added to one of these (Edrisal®) to increase its effectiveness. Attempting to get the full adrenergic effect, Morton[9] reported good results with intravenous amphetamine at the height of the attack. Some patients developed "crying jags," but most become euphoric.

It is appropriate here to tell of a recent survey made to pre-test among student nurses two new drug combinations in the treatment of dysmenorrhea. Each contained a new analgesic, an antispasmodic of the belladonna group, and B-complex with a high niacin ratio. In addition one tablet contained amphetamine. Some students, previously treated with success with Edrisal®, were failures on both tablets despite evidence of amphetamine response. When "unrelieved," relief was obtained by taking their preferred original medication. In others bizarre bleeding responses developed until they were reassured that the tablet contained no hormones. The niacin flush was considered allergic hives by several. Responses varied from month to month with the subject's general physical and emotional stability. It is for this reason that statistical results were not evaluated, and are not appended here.

When inhibition of ovulation is desired, stilbestrol is least costly, although other natural and synthetic estrogens are equally effective in appropriate dose. Patients are started on the fourth day of the cycle on 1 mg. daily. This is increased by 1 mg. daily on the 9th, 14th and 19th days, and medication is discontinued on the 24th day. Should breakthrough bleeding occur, the dose is immediately doubled for the balance of the cycle. The next cycle is then started at 2 or 3 mg. daily and increased as per schedule. The newer progestogens will also inhibit ovulation when taken from the 5th through the 25th day. Dosage varies from 5 to 10 mg. twice daily, according to the patient's needs. In some, nausea will occur during treatment, and bleeding may occur should the medication be taken irregularly. Inhibition of ovulation should be discontinued after three or four months. The diagnostic evaluation should be completed during this interval.

Although progesterone seldom is effective in the treatment of primary dysmenorrhea, which occurs only in the presence of ovulation, the newer progestational drugs have been helpful. Norethindrone (Norlutin®) and norethynodrel (with added methyl ether of ethinyl estradiol—Enovid®) have adequate estrogenic effectiveness whereas the substituted progesterones (Braxorone®, Pradox®) need supplemental estrogen. Delalutin®, another substituted progesterone, also requires estrogen but was additionally unsatisfactory because of its indefinite end point. In some subjects norethandrolone (Nilevar®) has androgenic side effects. Its anabolic effects (10 mg. t. i. d. for 1 to 2 weeks) may be helpful, however, in the general physical improvement of the patient. Other androgens such as methyl testosterone may be of great temporary value when given the last 10 days of the cycle. Dosage should never exceed 250 mg. per month, and medication must be stopped immediately with the development of any androgenic effect.

The progestogens often are highly successful when given from the 15th through the 25th day of the usual 28-day cycle. These results occur even though ovulation is not inhibited. This suggests that adequate endogenous progesterone may be causative, or that in these subjects the progestogens are metabolized into effective androgens. These concepts, however, do not account for those with dysmenorrhea and premenstrual acne cured of dysmenorrhea when their facial blemishes have disappeared or are satisfactorily covered.[7, 8]

Well over three-fourths of the patients will receive satisfactory relief with the previously outlined procedure. In the remainder, examination under anesthesia, cervical dilatation and possible curettage may be indicated in an attempt to find the true cause. Culdoscopy and exploratory colpotomy also may be considered. Many recover with marriage, or after childbearing, and the cure remains as much an enigma as the original disease. Pelvic neurectomy and uterine suspension

are mentioned only to be condemned. These may be useful in treating endometriosis, but not primary dysmenorrhea. Major pelvic surgery only leads to a gridiron abdomen with repeat operations by the same or another surgeon for "adhesions" or "cystic ovary." I might here interject and emphasize that resection of a cystic ovary, in many patients, leads to redevelopment of more and larger cysts. Reassurance and patient-physician rapport remain the best methods for continuous treatment. Drugs are merely temporizing, permitting the doctor to gain the full confidence of the patient (Chart 3).

### Conclusions

Premenstrual tension and dysmenorrhea are specific yet ill defined conditions affecting women from early menarche well into the climacteric. Premenstrual tension in its broadest sense occurs in 70 per cent but remains unrecognized by many a prospective patient, although actively acknowledged by her associates. Although 75 per cent of women have symptoms of congestion, less than 1 in 10 requires treatment. Approximately half have emotional disturbances as their primary complaint, and one-third require relief of pain. These subjects are in urgent need of assistance. Education is needed to overcome the resistance of patients in accepting the condition and its treatment. Multidimensional rather than specific therapy is stressed as being most beneficial since dehydration alone does not give sufficient relief. Education of the physician also is required, as good treatment is based on the understanding by the doctor of the patient's complex behavior at this time.

As in premenstrual tension, the treatment of dysmenorrhea is based on understanding. Primary relief can be given by inhibition of ovulation, or by analgesics, antispasmodic or analeptic drugs while gaining the patient's confidence. Secondary causes are excluded by a thorough physical examination. Improvement in general health is stressed, and conditions tending to aggravate symptoms identified that they might be avoided. These include prolonged standing, pelvic congestion, violent exercises and emotional or nervous fatigue. Basic treatment is outlined and major surgery is mentioned only to be condemned. The value of the newer steroids is presented and their use in conjunction with other drugs is delineated. Suggested dose schedules are given.

### Summary

The conditions called "premenstrual tension syndrome" and "primary dysmenorrhea" are briefly defined and described. Outlines of diagnostic procedures are given. Treatment is discussed. Physician-patient rapport is stressed in the management of both conditions. Recognition of the problem by physician and patient is required for proper understanding. The need for education enabling the patient to accept treat-

**CHART 3**

**PRIMARY DYSMENORRHEA**

1. Thorough History, Start Complete Physical Examination.
2. If Time Available, Inhibit Ovulation (3-4 months Maximum) Using Oral Estrogens or Progestogens 4th or 5th - 25th Days.
   (a) If Time Not Adequate, Give Analgesics and/or Hypnotics 1st Month, Then Inhibit Ovulation as Above.
3. Complete Physical Examination and Evaluation During This Interval.
4. Attempt Control by Other Drugs After Trial Period of Inhibition of Ovulation — To Be Done Only After Patient Knows Relief Is Obtainable.
   (a) Antispasmodics: Atropine — Atropine, Hyoscine, Papaverine. Adequate Amounts Premenstrually
   Anticholinergic — Banthine, Bentyl, Prantal — To Relief, During Attack
   Promazines — Phenergan (50-100 Mg.) Trilafon (8-24 Mg.) Oral or Rectal at Onset
   Mephanesin — Dimethylane — 250 Mg. Q.I.D. Premenstrually
   Benzyl Benzoate — ¼ - 1 Gm. Diluted, at Onset
   Ethyl Alcohol ..... at Onset
   (b) Sympathomimetic: d-Amphetamine (Up to 20 Mg.) Orally or Intravenously with Attack
   (c) Steroids: Progestogens — Enovid, Norlutin (10 - 20 Mg.) Daily 15th - 25th Day of Cycle
   — Nilevar (10 - 30 Mg.) Daily 15th - 25th Day of Cycle
   Androgens — (Methyl Testosterone — Not Over 250 Mg.) Last Half of Cycle
   (d) Analgesics & Hypnotics: To Effect
   (e) Mixtures of Above: Bendectin®, Premenstrually
5. Psychotherapeutic Evaluation Should Be Done as Indicated by Necessity.
6. Minor Surgery — Diagnostic — To Discover or Rule Out Hidden Secondary Causation.
   (a) Examination Under Anesthesia
   (b) Cervical Dilatation — Curettage (Polyps ?)
   (c) Culdoscopy or Exploratory Colpotomy

ment and the physician to give treatment is indicated.

Charts outlining the results of treatment of premenstrual tension syndrome are presented. Statistical analysis of the results in dysmenorrhea is avoided.

Multidimensional treatment of premenstrual tension syndrome is stressed, and surgical therapy of dysmenorrhea is deplored.


### Acknowledgments

The author expresses his appreciation to the following firms which furnished experimental drugs and adequate supplies.

| | |
|---|---|
| Ayerst Laboratories: | progesterone (Colprosterone ®) |
| Endo Laboratories, Inc.: | mercumatilin (Cumertilin ®) |
| Lederle Laboratories:* | acetazolamide (Diamox ®, Tentone ®) |
| The Wm. S. Merrell Company: | Bendectin ®, dicyclomine (Bentyl ®) |
| Parke, Davis & Company: | norethindrone (Norlutin ®) |
| The Purdue Frederick Co.: | Pre-Mens ® with supplements and placebo |
| Schering Corporation: | Ethisterone Compound T ®, diphemanil methylsulfate (Prantal ®), progesterone (Proluton ®), perphenazine (Trilafon ®) |
| G. D. Searle & Company: | methantheline bromide (Banthine ®), norethynodrel (Enovid ®), aminometramide (Mictine ®) and amisometradine (Rolicton ®) |
| E. R. Squibb & Sons: | 9-alpha-bromo-11-ketoprogesterone (Braxorone ®), 17—OH progesterone caproate (Delalutin ®) |
| The Upjohn Company: | ethoxzolamide (Cardrase ®) |
| Wyeth Laboratories: | promethazine (Phenergan ®) |

*Tentone (Diamox Compound C in Chart 2) for premenstrual tension is no longer made. The title has been assumed by a tranquilizer which is available.


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# Problems of Aging

PHYSICIANS can provide good advice and council to the groups advocating and supporting new types of housing projects for the aged. Medical society committees must be equipped to appraise the advantages or disadvantages of proposed housing for older people, keeping in mind that oldsters must remain active, independent, integral parts of the community as long as possible.

Nursing home administrators are anxious to have the advice and assistance of the physicians of the community. The county medical society committee on aging should offer to act in an advisory capacity to nursing homes. The physician must provide adequate instructions when his patient is admitted to a nursing home and make himself available for necessary visits to the patient when the occasion requires it. Active interest by physicians will improve the standards of nursing home care.

Medicine recognizes its responsibility in providing a positive approach to the problems of the medical care of the aging. All groups must assume a comprehensive look at the total problem, and active participation by physicians, nurses, hospitals and their staffs, nursing home administrators, welfare workers, service groups, and others is necessary to solve the many varied problems facing the aged.—Edward W. Cannady, M. D., in Illinois Medical Journal.

# Experience with Pancreatic Cyst in a General Hospital*†

*Victor S. Skaff, M. D., F. A. C. S., and Marion N. Malinowski, M. D.*

Although much progress has been made with regard to the surgical treatment of pancreatic cyst in its various forms during the past quarter-century, the subject remains one of considerable controversy.

### Incidence

Cyst of the pancreas occurs rarely and thus is encountered rarely by the pathologist or surgeon. Of 6,000 autopsies performed at Guy's Hospital, London, only four revealed the presence of the lesion.[1, 2] Judd[3] reported 88 cases, surgically treated, in 700,000 admissions to the Mayo Clinic, while Fallis and Barron[4] report 21 operative cases in approximately 650,000 registrations at Henry Ford Hospital.

In regard to our own observations, of a total of 76,311 surgical procedures performed at Charleston General Hospital during the period from May, 1942 to the present, it was found that only 8 were for the surgical cure of pancreatic cyst, and that the diagnosis in these 8 cases was made preoperatively.

### Classification

Classification of the various types of pancreatic cyst is well outlined by Maingot:[1]

A. Neoplastic cyst
   1. carcinoma
   2. teratoma

B. True pancreatic cyst
   1. parasitic cyst
      a. hydatid
      b. Cysticercus cellulosae
   2. nonparasitic cyst
      a. proliferative cyst (cystadenoma)
      b. degeneration cyst secondary to necrosis or hemorrhage
      c. congenital cyst associated with polycystic disease of the kidney and liver; dermoid cyst
      d. lymphatic cyst
      e. retention cyst which is lined with epithelium and is due to obstruction in the ducts or acini

C. False pancreatic cyst, or pseudocyst, produced by trauma, inflammation or degenerative changes in the interstitial tissue of the pancreas

Neoplastic cyst, according to Maingot, constitutes approximately 10 per cent of all pancreatic cysts encountered at operation or at autopsy. It is a degeneration cyst associated with benign or malignant tumor of the pancreas, usually involving the body or tail of that structure.

True pancreatic cyst is characterized by epithelial lining or is surrounded by pancreatic tissue.

Parasitic cyst is rare. Hemorrhagic cyst as well as lymphatic cyst has been reported following injury of the pancreas. Congenital cyst is considered to be due to a defect in development and in children must be differentiated from cystic fibrosis of the pancreas.

Retention cyst occurs as a result of obstruction of the pancreatic ducts by tumor, stone, or chronic relapsing pancreatitis.

Pseudocyst of the pancreas is characterized by absence of epithelial lining and is formed by extravasation of pancreatic juices into the lesser peritoneal sac as a result of rupture of one or more pancreatic ducts. It is surrounded by a wall of fibrous tissue, varies as to size, more often is unilocular than multilocular, and may be connected to any portion of the gland. Pseudocyst usually is localized between stomach and liver or stomach and transverse colon. In a majority of cases, its contents consist of old blood, necrotic tissue and pancreatic juice rich in diastatic ferments. The incidence rate of pseudocyst is approximately 20 per cent to 30 per cent of all pancreatic cysts.

### Some Etiologic Factors of Pseudocyst

Among etiologic factors are indirect trauma such as a crushing blow to the upper abdomen with compression of the pancreas against vertebrae, direct trauma due to surgical maneuvers around the pancreas or, according to Doubilet,[5, 6]


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**†Presented before the annual meeting of the West Virginia Chapter of the American College of Surgeons, at The Greenbrier in White Sulphur Springs, April 4, 1959.**

**Submitted to the Publication Committee, September 22, 1959.**

the basic injury results from reflux of concentrated bile, under tension, into the pancreatic ducts. This occurs by way of normal passages but only when the sphincter of Oddi is in spasm. Again (and this has the strongest support as the main etiology), pseudocyst may develop as a result of complications of acute or relapsing pancreatitis. Coexistence of biliary tract disease has been reported.

#### Clinical Manifestations of Pancreatic Cyst in General

Clinically, pancreatic cyst may produce little more than the disorder of pancreatic insufficiency or of gallbladder disease characterized by intermittent attacks of moderate or mild pain in the epigastric region, variable as to duration and frequency. On the other hand, the cyst's presence may be manifested by onset of acute epigastric pain, with tenderness, chills, fever and toxicity, suggestive of recurrent pancreatitis or repeated attacks of biliary colic. Jaundice may be present as a result of the extrahepatic pressure of the cyst on the common duct.

On physical examination, the most important observation is a palpable mass in the epigastrium.

#### Differential Diagnosis

The differential diagnosis lies between distended gallbladder, retroperitoneal tumor, mesenteric or omental cyst, cyst of the liver or spleen, and ovarian cyst. X-ray of the stomach, small bowel and gallbladder, results of certain laboratory tests such as elevated serum amylase, blood lipase, steatorrhea and the like, may be of help.

Waugh and Lynn[10] reported diabetes mellitus in 20 per cent of cases of pancreatic cyst.

#### Status of Conservative Treatment

Among complications which may follow conservative treatment of pancreatic cyst is intra-abdominal perforation with symptoms of acute peritonitis, which carries a high (occasionally up to 70 per cent) mortality rate.[7] Death may be due at times to cachexia.[8]

Eleven cases of pancreatic pseudocyst associated with hydrothorax are reported in the literature.[9]

#### Selecting the Suitable Surgical Method

In every case of suspected or proven pancreatic cyst, surgical intervention is necessary. Various surgical procedures and their relative merits are reported in the literature and are difficult to evaluate. To rule out malignancy all pancreatic cysts should be opened, inspected and biopsied. The technique selected must be fitted to the individual patient and the type of lesion to be dealt with. Either simple drainage or marsupialization in the case of the acutely ill patient with pancreatic necrosis oftentimes will prove a life-saving measure.

Gussenbauer,[1] in 1882, introduced the method of drainage and marsupialization of the cyst which, until recent years, was felt to be the method of choice by the great majority of observers. The low (4 per cent to 6 per cent) mortality rate and the simple surgical maneuver both contributed to general acceptance of the method. Excoriation of the skin, however, by the pancreatic enzymes, fistula formation, prolonged morbidity, and possibility of recurrence, all are disadvantages.

#### Ideal Surgical Method

If the anatomic relation and the thin-walled cyst permit, complete excision is the ideal method of treatment. Before attempting complete excision, however, due thought should be given the high (above 50 per cent) mortality rate[2, 8, 13] associated with unsuccessful results. In the treatment of certain degenerative or retention cysts localized in the tail of the pancreas, distal pancreatectomy is recommended.

#### Internal Drainage

The principle of drainage of the pancreatic pseudocyst into one of the hollow viscera of the upper gastrointestinal tract first was advocated by Jedlicka,[1] in 1923. Jurasz,[11] in 1929, modified the technique, using a transgastric approach, and the first pancreatic cystogastrostomy was successfully performed. Further attempts at drainage of the cyst into the gallbladder, the duodenum and, finally, the jejunum, were made.

In recent years, internal drainage of pancreatic pseudocyst, as advocated by several workers, has gained much ground as the method of choice in selected cases in which the cyst wall is suitable for anastomosis.[2, 8, 13, 14, 15] According to reports in the available literature, the results were poor in 14.8 per cent of cases in which cystogastrostomy was used; of those cases in which cystoduodenostomy was used, the results were poor in 14 per cent; results of treatment by cystojejunostomy, including the Roux Y technique, were poor in 13 per cent of cases.[8, 13] In no case in the group in which treatment was by internal drainage was there evidence of recurrence nor of regurgitation of gastrointestinal contents into the cyst cavity. In those cases terminating fatally, death was due to massive hemorrhage or to breakdown of the anastomosis.[8, 16]

From the physiologic standpoint, cystoduodenostomy should be the favored procedure.

Cystogastrostomy has been widely used, however, and cystojejunostomy, especially the Roux Y principle, has been the most generally accepted and has been accomplished with little risk.[8, 14]

### Pseudocyst and Sphincterotomy

According to Doubilet,[6] pancreatic pseudocyst is a complication of acute, necrotizing pancreatitis, and definitive treatment consists of section of the sphincter of Oddi. The procedure, he states, not only allows the pseudocyst to collapse and disappear but also arrests the underlying pancreatitis. Operative pancreatograms are mandatory in order to eliminate the possibility of partial obstruction by calculus, tumor or stricture; otherwise, sphincterotomy will fail. No statistical aproach to this statement was available, nor did a survey of the literature produce evidence to support it. A case in which treatment was by sphincterotomy is included among those reported in the present series.

### Case Reports

*Case 1.*—M. W., a white male aged 39 years, was admitted to the hospital in May, 1942, complaining of epigastric pain of three years' duration, gradual in onset. There had been some slight weight loss.

On physical examination, a rather firm, large mass filling the entire left upper abdominal quadrant as well as the epigastrium was palpable.

The laboratory findings were not remarkable except for serum amylase 1:128.

Colon x-ray was negative. An x-ray of the stomach showed a large tissue tumor in the epigastrium, displacing the stomach anteriorly.

Operation: Exploratory laparotomy performed May 29, 1942, revealed a cystic mass approximately the size of a cocoanut over the pancreatic area and within the lesser peritoneal cavity. Treatment consisted of drainage and marsupialization.

The pathologic diagnosis of the cyst contents was, "hemorrhagic fluid from pancreatic pseudocyst, with high concentration of diastatic ferment."

The postoperative course was without incident, and the patient was discharged from the Hospital on June 10, 1942, with a large Penrose drain still in place.

He was readmitted, March 21, 1943, complaining of abdominal pain, also of a large mass in the epigastrium. The pain was associated with the ingestion of food. Following his operation, May 29, 1942, a fistulous tract had developed, drainage persisting for seven months.

On examination, a large, soft, abdominal mass was palpated, beginning in the left upper abdominal quadrant and extending down to the umbilicus. The patient appeared to be in considerable abdominal distress.

Operation: On abdominal exploration, a mass of adhesions was found. There was no evidence of recurrence of pseudocyst.

*Case 2.*—L. G., a white female aged 44 years, was admitted to the hospital, January 8, 1945, because of a mass in the epigastrium since summer (1944). There had been no associated discomfort until approximately three months prior to admission, when loss of appetite had begun to develop, along with occasional bouts of nausea not accompanied by vomiting.

On examination there was a freely movable, palpably nontender mass, located in the right upper abdominal quadrant.

The laboratory work was not remarkable. X-ray of the stomach and colon showed a large cyst of the pancreas.

Operation: Exploration of the abdomen, January 12, 1945, disclosed a large pancreatic cyst occupying the entire midepigastrium. A specimen of the cyst was removed for biopsy purposes and marsupialization of the sac then was accomplished without incident.

Pathologic diagnosis: "Pancreatic cyst, probably originating from congenital anomaly of the ducts."

*Case 3.*—R. R., a white female aged 57 years, was admitted to the hospital, September 29, 1949, complaining of jaundice (present since June), intermittent attacks of severe abdominal pain, and a "lump" in the upper abdomen for the past two to three years. The first attack of pain had occurred five years previously, with no more until June, 1949.

On examination, palpable fullness on the right side of the abdomen was observed and interpreted as the liver, enlarged. Just to the right of the umbilicus and extending deeply into the right flank was a large, firm, slightly tender mass.

Laboratory work: Cephalin flocculation test was negative, and findings otherwise were essentially within normal limits. An x-ray of the gallbladder showed nonfunction of that organ.

Operation: Exploratory laparotomy, October 5, 1949, revealed the liver to be down to the iliac

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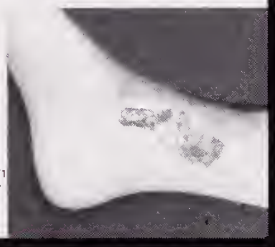

VARICOSE
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rapidly spreading
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healed within
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INFECTED
LACERATION
arked reversal
in 3 days . . .
returned
to school . . .
sure advanced[1]

THROMBOPHLEBITIS
back on his feet
in a week after
recurrent episode[1]

REFRACTORY
CELLULITIS
normal routine
resumed after 4 days
of VARIDASE[1]

crest; there was also distention of the common duct and the gallbladder.

Cholecystojejunostomy and jejunojejunostomy were accomplished at this time, and the common duct explored. A large cyst of the head of the pancreas, with complete obstruction of pancreatic and bile ducts, was discovered. A biopsy specimen of the cyst was removed, causing the outpouring of a large quantity of fluid. The cyst was treated by simple drainage.

Pathologic diagnosis: "Pancreatic pseudocyst rich in diastatic ferments."

After an uneventful postoperative course, the patient was discharged. Office follow-up showed the pancreatic fistula closed in six weeks' time. In this case, death, from carcinoma of the pancreas, occurred one year later.

*Case 4.*—R. M., a 61-year-old white male, was admitted to the hospital from the emergency room, February 15, 1952, having been involved in an automobile accident.

Physical examination showed lacerations and contusions of the face, with fracture, bilateral, of the maxillary and nasal bones.

The laboratory findings were essentially within normal limits except for the sedimentation rate (105 mm. in 1 hour) and the cephalin flocculation test (2 plus).

Operation: The bilateral maxillary fracture was repaired February 21 by the open reduction method. Postoperatively, except for intermittent attacks of nausea and vomiting, the patient got along very well until the fifth day when a large mass was palpated in the right upper abdominal quadrant. The abdomen was soft, with moderate tenderness. Immediate surgical exploration disclosed a large pancreatic pseudocyst behind the stomach, in the lesser peritoneal cavity. The cyst originated in the head of the pancreas; its contents consisted of milky fluid in large quantity. Simple drainage was performed.

Pathologic diagnosis: "Necrotic tissue from pancreatic autodigestion."

The patient was discharged from the hospital, April 25, 1952, improved, and with minimal fistulous drainage.

On April 26th, twenty-four hours after his discharge, he was readmitted because of a sudden onset of severe epigastric pain and associated "cold sweat."

Examination revealed tenderness both in the epigastric region and the upper abdominal quadrant, with muscle guarding. No definite mass was felt. The old transverse incision and stab wound of the epigastrium had healed well.

Laboratory work showed the serum amylase test to be positive 1:4. It was believed that at the time of his readmission the patient had mild pancreatitis. A conservative course was followed, antibiotics were administered, and he was discharged improved, April 27, 1952.

*Case 5.*—O. B., a white male aged 50 years, was admitted to the hospital, April 11, 1956, with the chief complaint of epigastric pain accompanied by nausea. There had been a slight weight loss. He had been admitted previously (August, 1955) on the medical service for treatment of chronic alcoholism and general malnutrition. From the date of his discharge in August, 1955, until April, 1956, there had been no real episode of acute abdominal pain.

Physical examination at the time of the current admission revealed a large mass occupying the epigastrium and the entire left upper quadrant of the abdomen. The mass was smooth, nontender, and approximately the size of a large grapefruit.

Laboratory work was essentially negative; the sedimentation rate was 81 mm. in 1 hour.

X-ray of the entire gastrointestinal tract showed an abdominal mass outside the large and small bowel.

Operation: Exploratory laparotomy April 17, 1956, revealed a large pseudocyst apparently arising from the head of the pancreas and densely adherent both to the large and small bowel. Treatment consisted of internal drainage by anastomosing the cyst to the duodenum. Approximately 500 cc's of straw-colored fluid were evacuated and a specimen of the cyst removed for biopsy purposes.

Pathologic diagnosis: "Atrophic pancreatic tissue with no evidence of malignancy" and "Fluid with high concentration of amylase."

Following an uneventful postoperative course, the patient was discharged from the Hospital, April 30, 1956.

He was admitted again May 12, 1956, complaining of abdominal pain, also nausea without vomiting, of three to four days' duration. There was associated anorexia.

The laboratory work was not remarkable except for the blood count which showed 13,000 leukocytes with 85 per cent polymorphonuclear and 1 stab.

The diagnosis on this admission was "pancreatitis, mild." Supportive and antibiotic therapy resulted in subsidence of symptoms.

Repeat films of the stomach and duodenum revealed a small diverticulum in the second portion of the duodenum, the site of the previous cystoduodenostomy. The pseudocyst apparently had become obliterated since the surgical procedure. The patient was permitted to leave the hospital on May 22, 1956, to be followed-up on an ambulatory basis. To date, he has remained well.

*Case 6.*—R. Y., a white male aged 41 years, was admitted to the hospital, January 18, 1956, complaining of a "lump" in the abdomen, present since the previous April (approximately 10 months). There was a history of subtotal gastrectomy (February, 1955), and of serum hepatitis (May-June, 1955). Five days prior to the present admission epigastric soreness had developed. Repeat x-ray of the stomach was reported as normal.

Essentially the only positive finding at this time was a freely movable, palpably nontender, abdominal mass 8 cm. in diameter.

Laboratory work was negative.

Operation: At exploration, January 19, 1956, local excision of the pancreas along with excision of a pseudocyst was performed. Suction drainage, to remain for several days, was placed over the wound.

Pathologic diagnosis: "Pseudocyst of pancreas, probably nontraumatic." Chemical analysis of the cyst's contents showed 250 units of amylase by the Somogyi method.

The patient was discharged improved, January 28, 1956, and has remained well to the present time.

*Case 7.*—V. E., a white female aged 50 years, first was admitted to the hospital, September 21, 1952. Her chief complaint was abdominal distress and, to some extent, nervousness. Blood pressure 160/106. The liver edge was questionably palpable. Treatment was symptomatic, and her condition on discharge was somewhat improved.

A few days later she again was admitted, vomiting and headaches now being added to her original complaints. Again, treatment was symtomatic.

The patient's third hospital admission date was March 15, 1953. Her complaints were anorexia, rather marked weight loss (18 pounds in 2 months), occasional bouts of diarrhea, nausea on occasion, and vomiting. In addition, for the three weeks just prior to the present admission, she had had upper abdominal pain.

On physical examination, there was a hard mass in the left upper abdominal quadrant, 8 cm. in diameter. On reviewing the laboratory work, the CBC was found to be normal, fasting blood sugar 144 per cent, and the urine positive for albumen, sugar and acetone.

Operation: At exploratory laparotomy, March 23, 1953, aspiration, removal of a biopsy specimen, and marsupialization of a pancreatic cyst were accomplished without incident.

Pathologic diagnosis: "Fibrous wall of a pseudocyst, probably arising from pancreas." Amylase of pancreatic fluid: control 1:32, test 1:2000.

The patient's condition on discharge from the hospital was excellent. Fistulous drainage, however, persisted for six weeks.

Date of the patient's fourth admission to the hospital was September 22, 1957, four years and six months after her successful surgery for pancreatic cyst.

Positive findings at this time were enlargement of the liver, ascites and jaundice. She was known to have episodes of excessive alcohol intake. Treatment was symptomatic and her condition was unchanged at the time of discharge, October 3, 1957.

On her final hospital admission twelve days later (October 15, 1957), she was comatose; jaundice, hepatomegaly to a high degree, and ascites were present.

Laboratory work showed sugar 158 mg., per cent; serum chlorides 87 mEq.; Van den Bergh—total, 4 mg. per cent; nonprotein nitrogen 177.5 mg. per cent. An electrocardiogram was within normal limits.

The patient remained comatose, and expired October 21, 1957. Permission for autopsy was granted.

At autopsy, there was no sign of recurrence of pancreatic pseudocyst. Fibrosis and atrophy of the pancreas, with residual inflammation, were noted.

The cause of death was portal cirrhosis complicated by ascites, marked jaundice and hepatic coma.

*Case 8.*—P. E., a white male aged 34 years, was admitted to the hospital on June 26, 1953, with

the complaint of severe epigastric pain. He had had localized pain for one year; there had been no radiation. He was toxic, dehydrated and obviously acutely ill.

The laboratory reported amylase 610 Somogyi units.

Operation: Laparotomy, performed July 16, 1953, at the end of a stormy preoperative course, disclosed a pseudocyst of the pancreas involving the entire lesser peritoneal cavity. The cyst was drained and there followed complete and uneventful recovery. Wound drainage lasted approximately six weeks.

Four months later the patient was readmitted, acutely ill, and in a state of dehydration and acidosis. A mass was palpable in the abdomen and after several days' supportive therapy, laparotomy was performed and the cyst again was drained, followed by sphincterotomy, after which a probe was passed up into the pancreatic duct without difficulty; there was no evidence whatever of obstruction.

The patient has been readmitted to the hospital on two occasions for treatment of pancreatitis following bouts of alcoholic intake. Since the time of his last operation, however, there has been no recurrence of the cystic mass, and x-ray has shown no displacement of the stomach.

### Summary

Eight cases of pancreatic cyst treated at Charleston General Hospital during the period from May, 1942 to September, 1957, are reported. Three patients were females and five were males. The age of the oldest patient was 61 years, that of the youngest, 34 years, the average age being 47 years. Pain—moderate or severe, intermittent or continuous—and a palpable mass in the upper abdomen were the most consistent findings clinically.

In 2 cases, there was a history of trauma, both direct and indirect; in 3 cases, a history of chronic pancreatitis was elicited; in 1 case, congenital cyst was recorded; in 2 cases, the etiology was unknown.

In 7 of the 8 cases in the series, the reported pancreatic cyst was pseudocyst; in the remaining case, the lesion was classified as congenital. In all cases, contents of the cysts were rich in diastatic ferments. One case, in addition to the palpable abdominal mass, was marked by severe jaundice due to pressure of the pseudocyst on the common bile duct.

In 3 cases, treatment consisted of simple drainage. In one of these there was recurrence, successfully treated by sphincterotomy. In 3 cases, the cyst was marsupialized; in 1 case, internal drainage (cystoduodenostomy) was performed; in 1 case, the cyst was excised *in toto*.

Complications in the wake of surgery occurred in 3 cases. In one of these (a case in which marsupialization had been performed), a palpable mass was noted on follow-up examination. Exploratory laparotomy disclosed a mass of adhesions but no sign of recurrence of the pseudocyst. In the other 2 cases, the patients returned with symptoms of mild pancreatitis which subsided on supportive and antibiotic therapy. One of these patients also had had marsupialization of the cyst; the other had had internal drainage. In all cases in which internal drainage was employed, there was evidence, consisting of x-ray records, to show that the cyst had become obliterated in one month following surgery.

### Results

There were 2 deaths (not immediate). In one case, in which treatment had consisted of simple drainage and cholecystojejunostomy, death from carcinoma of the pancreas occurred one year later. In the other case, in which marsupialization of the cyst had been done, the patient died four years later, death being due to severe cirrhosis of the liver, with hepatic coma. Autopsy in this case disclosed no evidence of recurrence of pancreatic pseudocyst.

### Conclusions

The treatment of pancreatic cyst is surgical. In our series of 8 cases, the number in which reoperation was necessary after external drainage does not approximate, on a per cent basis, that found in the literature. It was noted in most surveys that in one-fourth (25 per cent) of the cases in which treatment had consisted of external drainage, with or without marsupialization, reoperation was necessary. This disadvantage could be overlooked if the mortality rate were significantly lower than that of other, more effective, procedures. On the other hand, external drainage is indicated in the occasional case in which the patient cannot tolerate a longer operation.

In a small series of cases such as ours, fair assessment of the value of surgical methods currently in use is difficult. It is felt, however, that in the treatment of pancreatic cyst, choice of the ideal method lies between excision *in toto* and internal drainage.

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# The Physician and Practical Politics

Elected political representatives of the people on state and national levels justifiably complain that although physicians ask much of them on specific legislative issues, physicians, individually and collectively, are noticeably absent when the same legislators are seeking support for their election campaigns or for the political party they represent.

Physicians, heeding too literally Oliver Wendell Holmes' advice not to dabble in the muddy waters of politics, traditionally shun active participation in party organization, and from all indications go out of their way to avoid involvement in local political campaigns. There is apparently a fear among them that to stand up and be counted publicly in these local campaigns will besmirch their reputations, and that partisan politics will cause them to lose friends and alienate patients.

Unfortunately, they have, in their reluctance to participate, delegated to their state and national organizations responsibilities in the field of political action that only they, as individual physicians, can effectively fulfill. Principles and policies may be politically championed by state medical societies or by the American Medical Association. By their nature, however, these organizations cannot participate in partisan politics involving the financial, moral and physical support of specific candidates and parties.

However hackneyed the expression "support of political parties and backing of individual candidates are the responsibilities of citizenship" may have become through constant repetition, it has lost none of its truth. Physicians as citizens, intelligent, informed and respected, owe it to the position that they occupy in society to become more actively engaged in the affairs of local, state and national government. Only by such participation can the art of practical politics be elevated to the position of dignity that it deserves.

By failing to become identified with political campaigns or to participate in partisan politics, a physician has more to lose than the few, if any, friends or patients that might be alienated by such action. A far greater loss may be that of the private practice of medicine as an institution, the freedom of individual opportunity and the high standards of medical care that he, as a physician, is dedicated to protect.—New England Journal of Medicine.

# Congenital Malformations in West Virginia

## (As Reported on Birth Certificates in the Division of Vital Statistics of the West Virginia State Department of Health, for the Period 1954-1958, Inclusive)

*Thomas R. Poole*

For the five-year period of 1954 to 1958, inclusive, a total of 231,307 infants were reported as having been born alive in West Virginia. Among these live births 1864 were reported as having some type of malformation. This is an incidence of 8.05 per 1000 live births, or a rate of one malformed infant per 124.09 live births. The information was obtained by viewing microfilm copies of birth certificates to detect positive entries of congenital malformations. From the certificate number on the microfilm copy reference was made to the original certificate from which all pertinent data were recorded. The method used provided information on the total occurrences of live births in the state and thus included the births from mothers whose usual residence was not West Virginia. The majority of these were from bordering states and represent 109 of the total 1864 malformed infants.

In a study of this type a number of factors limit the absolute accuracy of the figures reported. Since the malformations considered represent only those reported, it can be presumed that some defects were not noticed at birth and thus not recorded. The report considers only anomalies occurring in live births and omitted those occurring in stillbirths. The occurrence of multiple anomalies in the same infant also makes an accurate statistical study more difficult.

### Incidence and Types of Malformations

There is at present no standardized classification of congenital anomalies and consequently some difficulties are encountered in making comparative studies. To save space the presentation in Table I is somewhat limited to the more common malformations and the more rare occurrences are classed as "miscellaneous" under the appropriate system. The relatively constant yearly total occurrences of malformations can be observed from the table.

The incidence found in this study of 8.05 anomalies per 1000 live births varies only slightly from figures reported by other investigators. Hendricks[5] reported an incidence of 7.4 per 1000 live births, Ivy[6] found 8.5 per 1000 live births, and Wallace et al[12] reported from New York City 9.20 per 1000 live births and from upstate New York 10.6 per 1000 live births. Based on studies of death certificates in the Philadelphia area for the period of 1929 to 1933, Murphy[8] estimated that congenital anomalies occurred in approximately 4.7 per 1000 live births. Shapiro et al[11] included anomalies discovered in the neonatal period by studying hospital charts of the infants and thus reported a higher incidence of malformations with a rate of 19.9 per 1000 live births.

Table II gives the usual residence of the mother by county and the incidence of anomalies by county per 1000 live births. No attempt will be made at this time to explain the variations among the counties. The figures are based on resident births as reported by the Division of Vital Statistics and this study included the delayed certificates which, for various reasons, were not filed at the time the Division made the report.

The malformations listed in Table I and the incidences reported therein are generally in agreement with those of other studies and therefore only the variants will be discussed. However, several facts concerning congenital malformations should be pointed out. Club foot and cleft lip and/or cleft palate are 1 and 2 in frequency each year, with spina bifida and atelectasis alternating in third and fourth places. Hydrocephalus is the most common brain defect and hypospadias accounts for the majority of the genitourinary anomalies. Imperforate anus is the most common malformation of the gastrointestinal tract. In this study by far the most common defect of the fingers is polydactylism of which there were 70 cases against 27 oligodactylia and 24 syndactylia. This supports the findings of Ivy[6] but is contrary to that of Bunnell[3] who states that syndactylism


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Submitted to the Publication Committee, August 12, 1959.

is the commonest congenital deformity of the hand. Of the toes, syndactylism is slightly more prevalent. The major malformations in order of frequency can be observed in Table IV. Table V shows that the combination of cleft palate and cleft lip is the most frequent combined anomaly. Club foot with spina bifida is next in order followed by spina bifida and hydrocephalus. The

**TABLE I**

**Congenital Anomalies Recorded on Birth Certificates**
**1954 - 1958, Inclusive**

| *Type* | *1954* | *1955* | *1956* | *1957* | *1958* | *Total* | *Incidence per 1000 live births* |
|---|---|---|---|---|---|---|---|
| Central Nervous System | | | | | | | |
| Anencephalus | 8 | 12 | 12 | 13 | 4 | 49 | 0.21 |
| Encephalocele | 1 | 3 | 2 | 1 | 2 | 9 | 0.039 |
| Hydrocephalus | 15 | 14 | 18 | 19 | 14 | 80 | 0.35 |
| Meningocele | 11 | 12 | 10 | 10 | 12 | 55 | 0.24 |
| Meningomyelocele | 3 | 5 | 3 | 7 | 4 | 22 | 0.10 |
| Mongolism | 6 | 10 | 15 | 12 | 13 | 56 | 0.24 |
| Spina bifida | 34 | 33 | 28 | 26 | 25 | 146 | 0.63 |
| Miscellaneous | 5 | 2 | 4 | 3 | 2 | 16 | 0.07 |
| Respiratory System | | | | | | | |
| Atelectasis (with or without pulmonary hyaline membrane) | 26 | 28 | 38 | 25 | 35 | 152 | 0.66 |
| Miscellaneous | 2 | 4 | 2 | 1 | 3 | 12 | 0.05 |
| Congenital Heart Disease | 24 | 23 | 30 | 29 | 29 | 135 | 0.58 |
| Musculoskeletal System | | | | | | | |
| Upper Extremity | | | | | | | |
| Adactylia | 2 | 2 | | 1 | 1 | 6 | 0.03 |
| Oligodactylia | 5 | 6 | 6 | 2 | 8 | 27 | 0.12 |
| Polydactylia | 16 | 14 | 10 | 10 | 20 | 70 | 0.30 |
| Syndactylia | 12 | 1 | | 7 | 4 | 24 | 0.10 |
| Clubbing | 7 | 1 | 1 | 2 | | 11 | 0.05 |
| Deformed forearm | 4 | 4 | 1 | 4 | 2 | 15 | 0.06 |
| Deformed hand | 3 | 10 | 3 | 3 | 4 | 23 | 0.10 |
| Lower Extremity | | | | | | | |
| Adactylia | | | | | 1 | 1 | 0.004 |
| Oligodactylia | | 6 | 2 | 2 | 1 | 11 | 0.05 |
| Polydactylia | 2 | 6 | 4 | 2 | 6 | 20 | 0.09 |
| Syndactylia | 5 | 3 | 4 | 7 | 8 | 27 | 0.12 |
| Clubbing | 52 | 54 | 55 | 49 | 58 | 268 | 1.16 |
| Deformed legs or feet | 3 | 15 | 10 | 8 | 13 | 49 | 0.21 |
| Cleft lip | 17 | 18 | 10 | 16 | 16 | 77 | 0.33 |
| Cleft palate | 15 | 16 | 8 | 12 | 16 | 67 | 0.29 |
| Cleft lip and palate | 28 | 19 | 25 | 25 | 21 | 118 | 0.51 |
| Cranial defect | | 2 | 2 | 4 | 3 | 11 | 0.05 |
| Achondroplasia | | 1 | 3 | 3 | 1 | 8 | 0.03 |
| Dislocation of hip | 1 | 1 | 5 | 1 | 1 | 9 | 0.04 |
| Dislocation of knee | 1 | 3 | | | 1 | 5 | 0.02 |
| Genu recurvatum | 1 | 2 | | 1 | 1 | 5 | 0.02 |
| Other musculoskeletal defects | 22 | 3 | 8 | 11 | 11 | 55 | 0.24 |
| Gastrointestinal Tract | | | | | | | |
| Eventration | 2 | | | 2 | | 4 | 0.02 |
| Intestinal obstruction | 5 | | 1 | 1 | | 7 | 0.03 |
| Biliary defect | 2 | | | | 1 | 3 | 0.01 |
| Tracheo-esophageal fistula | 6 | 1 | 3 | 5 | 2 | 17 | 0.07 |
| Atresia or stenosis of bowel | 1 | 1 | 3 | 1 | 3 | 9 | 0.04 |
| Imperforate anus | 10 | 8 | 8 | 1 | 8 | 35 | 0.15 |
| Enlarged liver and/or spleen | 3 | 2 | 1 | 2 | 2 | 10 | 0.04 |
| Miscellaneous malformations | 7 | 4 | 4 | 4 | 5 | 24 | 0.10 |
| Genitourinary Tract | | | | | | | |
| Hypospadias | 13 | 15 | 11 | 13 | 25 | 77 | 0.33 |
| Hydrocele | | 1 | 3 | | 4 | 8 | 0.03 |
| Penis or scrotal anomaly | 2 | 1 | | 4 | 1 | 8 | 0.03 |
| Agenitalia | 1 | | 1 | | | 2 | 0.009 |
| Hermaphroditism | | 1 | | 1 | | 2 | 0.009 |
| Vaginal malformation | 1 | | 1 | 3 | 1 | 6 | 0.03 |
| Bladder exstrophy | 5 | 2 | | 2 | 2 | 11 | 0.05 |
| Polycystic kidney | | 1 | 1 | 1 | 1 | 4 | 0.02 |
| Other kidney defect | | 2 | 2 | | 2 | 6 | 0.03 |
| Miscellaneous | 5 | 1 | 4 | 4 | 5 | 19 | 0.08 |
| Eye | | | | | | | |
| Anophthalmus | 2 | 1 | 1 | 1 | | 5 | 0.02 |
| Miscellaneous | 3 | | | 1 | 1 | 5 | 0.02 |
| Ear | | | | | | | |
| Absence | 2 | | 1 | 2 | | 5 | 0.02 |
| Imperforate | | 1 | | 1 | 2 | 4 | 0.02 |
| Other | 5 | 6 | 5 | 1 | 10 | 27 | 0.12 |
| Nose | | | | | | | |
| Absent or deformed | 3 | | | | 1 | 4 | 0.02 |
| Hernia | | | | | | | |
| Inguinal | 1 | 2 | | 1 | 3 | 7 | 0.03 |
| Umbilical | 4 | 1 | 5 | 5 | 9 | 24 | 0.10 |
| Other | | 3 | | 1 | | 4 | 0.02 |
| Blood Dyscrasia | | | 1 | 1 | 1 | 3 | 0.01 |
| Skin — Miscellaneous | | 2 | 3 | 1 | 1 | 7 | 0.03 |
| Tumors and Cysts | | | | | | | |
| Hemangioma | 4 | 4 | 1 | 4 | 5 | 18 | 0.08 |
| Teratoma | | 2 | | 2 | | 4 | 0.02 |
| Unspecified tumors | 2 | 4 | 5 | | 5 | 16 | 0.07 |
| Miscellaneous cysts | 2 | | 2 | 1 | 3 | 8 | 0.03 |
| Unspecified anomalies | 23 | 16 | 19 | 25 | 22 | 105 | 0.45 |
| TOTAL | 445 | 415 | 405 | 407 | 465 | 2137 | 9.231 |

frequency with which club foot occurs with other malformations should be noted.

Warkany[13] noted that frequently congenital deformities tended to predominate in the male, and favored the left side. Conversely, Bagg and Little[1] noted a variation in that they found polydactylism in 61 females and 30 males. Sixty deformities were on the right side and 27 on the left. Our findings tend to predominate on the right side but a large number of unspecified cases prevents an accurate estimate. The more frequent occurrence of anomalies in males than females is reported also by other workers.[5, 7, 8] The present study supports their findings with a male preponderance over female (Table III). Some exceptions to this are in the central nervous system defects and a type of cleft palate without cleft lip. In these the female predominates. Ivy[6] found umbilical hernias to be more common in females in a ratio of 2:1. Shapiro et al[11] reported this defect as being nine times more frequent in females. We have found 14 males with umbilical hernias compared to 10 females.

There are conflicting reports in the literature[5, 7, 8, 11] as to the predominance of congenital malformations in a particular race. No great differences are reported, however, and in this presentation 77 of the total 1864 malformed infants were from non-white parents.

### Maternal Age and Parity

From Table VII it can be observed that over half of the total malformed infants are born to mothers of age 20 to 29 years. This is expected since this represents the age range when childbearing is greater. The incidence of anomalies seems to be proportionally greater on either end of this childbearing period. This agrees closely with the report by Hendricks.[5] Probably the greatest attempt to correlate maternal age with a specific malformation has been with mongolism. Book and Reed[2] state that mongolism rises in frequency with age, being found 40 times more often in mothers beyond the age of 45 than in mothers in the middle reproductive years. Dodge and Adams reporting in Harrison's[4] Principles of Internal Medicine say the mean age of mothers having mongoloid infants is 37. Our findings show mongolism more prevalent in infants from younger mothers with the mean age being 32.09± 8.12 in 56 reported cases.

Table VI indicates the parity of the mothers of malformed infants. It can be seen that 30 per cent of the mothers were primiparas and 3 per cent had 10 or more previous children. These figures include both live born and stillborn pregnancies.

### Birth Weight

The frequency of infants with malformations relative to birth weights can be observed in Table IX. Seventy-eight per cent of the children were in the weight range of 5 to 8 pounds and 15 per cent were in the premature range. Thus, a greater incidence of anomalies per 1000 live births would appear to occur in the premature weight group. This is supported by the high incidence of prematurity as a complication of pregnancy in mothers of malformed infants, as seen in Table VIII, and agrees with reports from other workers.[5, 7, 12]

### Complications of Pregnancy

Table VIII gives a listing of the complications associated with the pregnancies of mothers who gave birth to malformed infants. It is seen that, with the exception of prematurity, polyhydram-

**TABLE II**

**Congenital Anomalies by County of Usual Residence of the Mother**

| *County* | *Total Malformations** | *Total Live births** | *Incidence per 1000 live births* |
|---|---|---|---|
| Barbour | 11 | 1,696 | 6.48 |
| Berkeley | 21 | 3,640 | 5.76 |
| Boone | 23 | 3,979 | 5.78 |
| Braxton | 10 | 1,765 | 5.66 |
| Brooke | 23 | 3,138 | 7.32 |
| Cabell | 92 | 12,777 | 7.20 |
| Calhoun | 5 | 859 | 5.82 |
| Clay | 26 | 1,749 | 14.86 |
| Doddridge | 2 | 624 | 3.20 |
| Fayette | 54 | 8,316 | 6.49 |
| Gilmer | 4 | 728 | 5.49 |
| Grant | 6 | 961 | 6.24 |
| Greenbrier | 33 | 4,229 | 7.80 |
| Hampshire | 1 | 1,137 | 0.87 |
| Hancock | 35 | 4,794 | 7.30 |
| Hardy | 5 | 1,002 | 4.99 |
| Harrison | 70 | 8,612 | 8.12 |
| Jackson | 9 | 1,736 | 5.18 |
| Jefferson | 19 | 2,222 | 8.55 |
| Kanawha | 297 | 32,067 | 9.26 |
| Lewis | 15 | 1,822 | 8.23 |
| Lincoln | 14 | 2,807 | 4.98 |
| Logan | 71 | 9,427 | 7.53 |
| McDowell | 80 | 11,247 | 7.11 |
| Marion | 49 | 5,312 | 9.22 |
| Marshall | 33 | 3,627 | 9.09 |
| Mason | 5 | 2,773 | 1.80 |
| Mercer | 46 | 8,278 | 5.55 |
| Mineral | 21 | 2,206 | 9.51 |
| Mingo | 30 | 6,324 | 4.74 |
| Monongalia | 69 | 6,215 | 11.10 |
| Monroe | 6 | 1,147 | 5.23 |
| Morgan | 8 | 1,052 | 7.60 |
| Nicholas | 46 | 3,378 | 13.61 |
| Ohio | 78 | 7,722 | 10.10 |
| Pendleton | 5 | 801 | 6.24 |
| Pleasants | 7 | 741 | 9.44 |
| Pocahontas | 11 | 1,084 | 10.14 |
| Preston | 34 | 3,242 | 10.48 |
| Putnam | 11 | 2,313 | 4.75 |
| Raleigh | 82 | 9,970 | 8.22 |
| Randolph | 27 | 2,945 | 9.16 |
| Ritchie | 17 | 919 | 18.49 |
| Roane | 7 | 1,437 | 4.87 |
| Summers | 8 | 1,771 | 4.51 |
| Taylor | 15 | 1,517 | 9.88 |
| Tucker | 4 | 846 | 4.72 |
| Tyler | 7 | 842 | 8.31 |
| Upshur | 23 | 2,019 | 11.39 |
| Wayne | 17 | 3,910 | 4.34 |
| Webster | 22 | 1,962 | 11.21 |
| Wetzel | 17 | 2,082 | 8.16 |
| Wirt | 1 | 432 | 2.31 |
| Wood | 86 | 9,250 | 9.29 |
| Wyoming | 37 | 5,045 | 7.33 |
| Total | 1,755 | 222,496 | |
| Out of state residents | 109 | | |

*1954 1958, Inclusive.

nios and breech presentation are the most common complications, followed closely by a number of other conditions. A study to correlate a complication of pregnancy with a particular type of malformation was not made. However, Prindle et al[10] found that 63 of 68 defective infants born to mothers with polyhydramnios had hydrocephalus, anencephalus, or spina bifida. Shapiro et al[11] noted that polyhydramnios occurred in 1.2 per cent of the mothers of malformed infants in their study. This compares with the 1.77 per cent found in our investigation. It seems pertinent that 22 per cent of the total malformations were accompanied by some type complication of the pregnancy.

### Seasonal Variation

The distribution of the malformed infants by the month of their births is presented in Table X. Murphy[8] noted a slight preponderance of conceptions of malformed children in the summer months, and Petersen[9] found a preponderance of conceptions in the spring months. On the other hand, Wallace et al[12] found no monthly trend descernible. No monthly trend is evident from our study.

### Summary


1. For the period of 1954 to 1958, inclusive, a total of 1864 infants were reported by birth certificate to have been born alive in West Virginia with one or more congenital malformations, an incidence of 8.05 per 1,000 live births.

2. Club foot and cleft lip and/or cleft palate are 1 and 2 in frequency each year, with spina bifida and atelectasis alternating in third and fourth places.

3. Hydrocephalus is the most common brain defect, hypospadias the most common genitourinary defect, imperforate anus the most common defect of the gastrointestinal tract and polydactylism is the most common malformation of the fingers.

4. Cleft palate and cleft lip is the most frequent combination of anomalies, with club foot and spina bifida next in order. There is a high incidence of club foot in combination with other anomalies.

5. Malformations tend to predominate in the male. Exceptions to this are disorders of the central nervous system and cleft palate without cleft lip.

6. Mongoloid infants were born to mothers with a mean age of 32.09± 8.12, substantially lower than generally reported.

7. Thirty per cent of mothers of the total malformed infants were primiparas. Fifteen per cent of the total malformed infants were in the premature weight range.

8. Twenty-two per cent of the total malformations were accompanied by some type complication of pregnancy. Polyhydramnios and breech presentation were frequent in the mothers of malformed infants.

9. No monthly trend was detected for the births of the malformed infants.


**TABLE III**

**Congenital Malformations by System and Sex, 1954 - 1958 Inclusive**

| Type | 1954 | | 1955 | | 1956 | | 1957 | | 1958 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Male* | *Female* | *Male* | *Female* | *Male* | *Female* | *Male* | *Female* | *Male* | *Female* | *Male* | *Female* |
| Extremity—Upper left | 8 | 10 | 6 | 3 | 4 | 4 | 7 | 2 | 7 | 7 | 32 | 26 |
| Upper right | 5 | 6 | 4 | 4 | 2 | 1 | 5 | 5 | 5 | 2 | 21 | 18 |
| Right and left | 6 | 12 | 7 | 7 | 4 | 4 | 5 | 1 | 5 | 5 | 27 | 29 |
| Extremity—Lower left | 3 | 3 | 2 | 10 | 3 | 5 | 11 | 12 | 8 | 8 | 27 | 38 |
| Lower right | 7 | 7 | 10 | 13 | 13 | 13 | 7 | 6 | 13 | 6 | 50 | 45 |
| Right and left | 20 | 19 | 16 | 21 | 14 | 18 | 13 | 11 | 21 | 13 | 84 | 82 |
| Not specified | 7 | 2 | 12 | 8 | 8 | 8 | 6 | 4 | 17 | 7 | 50 | 29 |
| Total left | 11 | 13 | 8 | 13 | 7 | 9 | 18 | 14 | 15 | 15 | 59 | 64 |
| Total right | 12 | 13 | 14 | 17 | 15 | 14 | 12 | 11 | 18 | 8 | 71 | 63 |
| Other skeletal malformations | 4 | 7 | 4 | 1 | 4 | 7 | 6 | 11 | 10 | 2 | 28 | 28 |
| Head | | | | | | | | | | | | |
| Cleft lip | 11 | 6 | 14 | 4 | 5 | 5 | 10 | 6 | 8 | 8 | 48 | 29 |
| Cleft palate | 5 | 10 | 4 | 12 | 4 | 4 | 5 | 7 | 9 | 7 | 27 | 40 |
| Cleft lip and palate | 16 | 12 | 13 | 6 | 18 | 7 | 17 | 8 | 10 | 11 | 74 | 44 |
| Respiratory and Chest | 14 | 15 | 16 | 15 | 27 | 11 | 11 | 14 | 22 | 16 | 90 | 71 |
| Central Nervous System | 37 | 34 | 26 | 51 | 31 | 48 | 38 | 39 | 30 | 33 | 162 | 205 |
| Congenital Heart Disease | 15 | 9 | 17 | 6 | 20 | 10 | 16 | 13 | 18 | 11 | 86 | 49 |
| Gastrointestinal Tract | 22 | 15 | 10 | 8 | 13 | 7 | 6 | 9 | 15 | 6 | 66 | 45 |
| Genitourinary Tract | 19 | 5 | 23 | | 17 | 3 | 19 | 3 | 34 | 3 | 112 | 14 |
| Eye | 2 | 2 | 1 | | | 1 | | 2 | 1 | | 4 | 5 |
| Ear | 3 | 4 | 2 | 4 | 6 | | 3 | 1 | 4 | 8 | 18 | 17 |
| Nose | | 3 | | | | | | | | 1 | | 4 |
| Tumors and Cysts | 6 | 3 | 4 | 6 | 6 | 2 | 2 | 5 | 4 | 8 | 22 | 24 |
| Hernia | | | | | | | | | | | | |
| Inguinal | 1 | | 2 | | | | 1 | | 3 | | 7 | |
| Umbilical | 3 | 1 | | 1 | 1 | 4 | 3 | 2 | 7 | 2 | 14 | 10 |
| Other | | | | 3 | | | 1 | | | | 1 | 3 |
| Blood Dyscrasia | | | | | | 1 | 1 | | 1 | | 2 | 1 |
| Miscellaneous anomalies | | 4 | 2 | | 1 | 4 | 1 | | 1 | 3 | 5 | 11 |
| Unspecified | 12 | 11 | 9 | 7 | 11 | 9 | 11 | 14 | 17 | 5 | 60 | 46 |
| Total | 226 | 200 | 204 | 190 | 212 | 176 | 205 | 175 | 270 | 172 | 1117 | 913 |

**Acknowledgments**

Grateful acknowledgments are due to N. H. Dyer, M. D., M. P. H., Director of the West Virginia State Department of Health, for providing the opportunity to pursue the problem; to Leon A. Dickerson, M. D., Director, Bureau of Disease Control, State Department of Health, for his supervision and guidance; and to Mr. Harry M. Huff, Acting Director, Division of Vital Statistics, State Department of Health, for his courteous assistance and for making available the necessary material from which the statistical data were obtained.

### TABLE IV

**Commonest Congenital Defects in Order of Frequency 1954 - 1958, Inclusive**

| *Type* | *No. Reported* | *Incidence per 1000 live births* |
|---|---|---|
| Club foot | 268 | 1.16 |
| Cleft lip and/or cleft palate | 262 | 1.13 |
| Atelectasis (with or without pulmonary hyaline membrane) | 152 | 0.66 |
| Spina bifida | 146 | 0.63 |
| Congenital heart disease | 135 | 0.58 |
| Malformed fingers* | 127 | 0.55 |
| Hydrocephalus | 80 | 0.35 |
| Hypospadias | 77 | 0.33 |
| Malformed toes | 59 | 0.26 |
| Mongolism | 56 | 0.24 |
| Meningocele | 55 | 0.24 |
| Anencephalus | 49 | 0.21 |
| Deformed legs or feet | 49 | 0.21 |
| Imperforate anus | 35 | 0.15 |
| Umbilical hernia | 24 | 0.10 |
| Total | 1574 | 6.80 |

The above constitute 84.4% of the total congenital malformations recorded in 1954-1958, inclusive.

*The 127 consist of polydactylia 70, oligodactylia 27, syndactylia 24, and adactylia 6.

### TABLE V

**Most Frequent Combinations of Anomalies 1954 - 1958, Inclusive**

| *Type* | *No. Reported* | *Incidence per 1000 live births* |
|---|---|---|
| Cleft palate + cleft lip | 118 | 0.51 |
| Club foot + spina bifida* | 25 | 0.11 |
| Spina bifida + hydrocephalus | 21 | 0.09 |
| Deformed upper and lower extremity—unspecified | 20 | 0.09 |
| Spina bifida + other CNS defects | 17 | 0.07 |
| Club foot + other CNS defects | 9 | 0.04 |
| Cleft palate and/or cleft lip + foot deformity | 5 | 0.02 |
| Club foot + imperforate anus | 3 | 0.01 |
| Hydrocephalus + other CNS defects | 3 | 0.01 |
| Enlarged liver and spleen | 3 | 0.01 |

*Seven of the total reported were associated with hydrocephalus also.

### TABLE VI

**Maternal Parity of 1846 Malformed Infants**

| *Parity* | *No. Malformations* | *Percent* |
|---|---|---|
| 1 | 552 | 29.9 |
| 2 | 405 | 21.9 |
| 3 | 325 | 17.6 |
| 4 | 198 | 10.7 |
| 5 | 118 | 6.4 |
| 6 | 67 | 3.6 |
| 7 | 53 | 2.9 |
| 8 | 37 | 2.0 |
| 9 | 30 | 1.6 |
| 10 or more | 61 | 3.3 |

### TABLE VII

**Maternal Age and Malformations Among 1858 Infants**

| *Age Range (years)* | *No. Malformations* | *Percent* |
|---|---|---|
| under 15 | 3 | 0.16 |
| 15 - 19 | 300 | 16.2 |
| 20 - 24 | 570 | 30.7 |
| 25 - 29 | 499 | 26.9 |
| 30 - 34 | 255 | 13.7 |
| 35 - 39 | 153 | 8.2 |
| 40 - 44 | 70 | 3.8 |
| over 44 | 8 | 0.43 |

### TABLE VIII

**Complications of Pregnancy in Birth of 1864 Malformed Infants**

| *Type* | *No. Reported* | *Percent* |
|---|---|---|
| Premature labor | 67 | 3.60 |
| Premature rupture of membranes | 33 | 1.77 |
| Polyhydramnios | 33 | 1.77 |
| Breech presentation | 33 | 1.77 |
| Preeclampsia; eclampsia | 24 | 1.29 |
| Cephalopelvic disproportion | 21 | 1.13 |
| Persistent posterior position | 19 | 1.02 |
| Abruptio placentae | 18 | 0.97 |
| Infectious process | 18 | 0.97 |
| Brow, face or transverse presentation | 17 | 0.91 |
| Dystocia | 15 | 0.80 |
| Placenta previa | 14 | 0.75 |
| Previous cesarean section | 13 | 0.69 |
| Toxemia | 13 | 0.69 |
| Cardiovascular disease | 11 | 0.59 |
| Blood disorder | 11 | 0.59 |
| Postmaturity | 10 | 0.54 |
| Hemorrhage | 9 | 0.48 |
| Rh sensitization | 9 | 0.48 |
| Twins | 8 | 0.43 |
| Diabetes mellitis | 6 | 0.32 |
| Edema | 6 | 0.32 |
| Severe nausea and vomiting | 5 | 0.27 |
| Miscellaneous | 24 | 1.29 |
| Total | 437 | 23.44 |

Although some of the complications occurred in combinations 410 (22%) of the total malformations were accompanied by some type complication of the pregnancy.

### TABLE IX

**Congenital Malformations According to Birth Weight 1954 - 1958, Inclusive**

| *lbs.* | *- lbs.* | *oz.* | *No. Reported* | *Percent* |
|---|---|---|---|---|
| 0 | 0 | 15 | 2 | 0.11 |
| 1 | 1 | 15 | 20 | 1.10 |
| 2 | 2 | 15 | 39 | 2.15 |
| 3 | 3 | 15 | 61 | 3.36 |
| 4 | 4 | 15 | 157 | 8.65 |
| 5 | 5 | 15 | 291 | 16.02 |
| 6 | 6 | 15 | 441 | 24.28 |
| 7 | 7 | 15 | 452 | 24.89 |
| 8 | 8 | 15 | 243 | 13.38 |
| 9 | 9 | 15 | 92 | 5.07 |
| 10 | 10 | 15 | 14 | 0.77 |
| 11 | 11 | 15 | 3 | 0.17 |
| 12 | 12 | 15 | | |
| 13 | 13 | 15 | 1 | 0.05 |
| Total | | | 1816 | 100.00 |

### TABLE X

**Congenital Malformations According to Month of Birth 1954 - 1958, Inclusive**

| *Month* | *No. Reported* | *Percent* |
|---|---|---|
| January | 161 | 8.64 |
| February | 144 | 7.73 |
| March | 146 | 7.83 |
| April | 147 | 7.89 |
| May | 150 | 8.05 |
| June | 151 | 8.10 |
| July | 183 | 9.82 |
| August | 148 | 7.94 |
| September | 163 | 8.75 |
| October | 153 | 8.20 |
| November | 160 | 8.58 |
| December | 158 | 8.48 |
| Total | 1864 | 100.00 |

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# Health Insurance and the Aged

At the present time, there are about 15 million people 65 years old or over in this country. The aged now constitute 8.6 per cent of the total population and by 1980 the figure will be about 10 per cent.

In 1957, about three out of every eight persons aged 65 or over in this country, had some form of voluntary health insurance. There are many others in this group who would like to have some form of insurance. The average insured person in this group had obtained his insurance over 10 years before, usually through his employment. The majority, 56 per cent, first obtain their insurance through a place of employment. The rest obtained it some other way such as when a salesman called, through friends or relatives, or through advertising, direct mail and other means.

The cost of this insurance as paid by this group ranged from less than $1 per month to $20 or more per month. The average was $4 per month. Less than 3 per cent of the total aged in this survey had tried to get insurance and been turned down.

Nearly two-thirds of the population aged 65 and over stated that they would like to have insurance covering all medical expenses. Others would like partial coverage, and 17 per cent were unwilling to pay anything for it. The majority, 54 per cent, were in favor of government insurance, while 43 per cent were against it; of those favoring government insurance, 80 per cent define these people in terms of economic need and even added some other qualifications.

Providing the aged with health insurance has become a major medical problem. Recently the American Medical Association has adopted a proposal under which doctors would treat aged persons with low incomes at reduced fees. Plans for financing the health needs of the aged may vary, but all should agree on one point: That a group of older persons responsible for their own health is an asset to society—and in keeping with our present attitudes toward independent active later life for all.—Donald N. McLeod, M. D., in Arizona Medicine.

# Special Article

## The Governor's Conference on Aging–1959*

*Cecil H. Underwood*
*Governor of West Virginia*

Let me first welcome you to the Governor's Conference on Aging. I appreciate the interest shown in this vital problem and I am sure that elderly people in our society truly are gratified by your concern.

I want especially to welcome and thank our visitors and guest speakers, Mr. Aycock and Miss Adkins, and the symposium leaders: Mr. Cecil B. Dodd, Mr. George Hansen, Mr. Leonard J. Pnakovich, Dr. B. C. Harrington, and Dr. N. H. Dyer.

Many people contributed in the planning and preparation for this meeting. They, of course, have my gratitude, as do the members of the Commission on Aging.

### Purpose of Conference

The purpose of this Conference might best be described through a brief history of the Commission on Aging. Founded in 1957, following the adoption of a Senate resolution, the Commission was continued by the Legislature at the regular session in 1959. During this time, it has been very active in the fields of health, housing, income, recreation and participation in community life for elderly citizens. It has worked in close cooperation with state departments including Employment Security, Workmen's Compensation, Health, Mental Health, Public Assistance, Labor, Veterans Affairs, and Vocational Rehabilitation, as well as with the federal Department of Health, Education and Welfare.

The object of the Commission is simply to study problems of aging. The objective of this meeting, with other meetings, is to plan a program to meet the needs of West Virginia's growing population of older citizens. A focal point for this study and for the work of this Conference is the White House Conference on Aging, which will be held in January, 1961. This national conference will be composed of representatives from every state who will bring with them information and recommendations garnered from state commissions and state conferences like this one.

***The Author***

- **Hon. Cecil H. Underwood, Governor of the State of West Virginia, The Capitol, Charleston, W. Va.**

### The White House Conference on Aging

In authorizing the White House Conference, the law declared ". . . that the federal government shall work jointly with the states and their citizens to develop recommendations and plans for action . . . which will serve the purpose of:

"1.—Assuring middle-aged and older persons equal opportunity with others to engage in gainful employment which they are capable of performing, thereby gaining for our economy the benefits of their skills, experience and productive capacities; and

"2.—Enabling retired persons to enjoy income sufficient for health and for participation in family and community life as self-respecting citizens; and

"3.—Providing housing suited to the needs of older persons and at prices they can afford to pay; and

"4.—Assisting middle-aged and older persons to make preparation, develop skills and interests, and find social contacts which will make the gift of added years of life a period of reward and satisfaction and avoid unnecessary social costs of premature deterioration and disability; and

"5.—Stepping up research designed to relieve old age of its burden of sickness, mental breakdown and social ostracism."

It should be noted that the Federal Government is simply to aid the states and local com-

*Presented before the Governor's Conference on Aging held at the Capitol in Charleston, September 25, 1959.
Submitted to the Publication Committee, November 6, 1959.

munities in this effort to understand and solve the problems of aging. The initiative and the most effective work is our responsibility.

### Increase in Average Life Span

The reason for this new concern with the problems of old age is obvious. In the past 55 years, the average life span has increased by 22 years. Until recently our population increased steadily but gradually and its impact was easily absorbed by society. But now the situation is different.

The number of older persons increased from 13½ million in 1900 to 49½ million in 1957. Those 65 or more are almost five times as many, 15 million now compared to 3 million at the turn of the century. This age group is expected to reach 21 million by 1975, only 15 years from now. In West Virginia, persons 45 and over constitute almost 28 per cent of the population; 163,000 of our citizens are over 65. Each month, the public employment offices in West Virginia receive an average of 1200 new applications from older job seekers.

Like all of us, older persons want—and are entitled to—economic security, housing, health services, opportunities for education, recreation and participation in family and community life. These are basic conditions for existence and society must provide them. If we meet these needs, the added years of life will have meaning—the meaning of usefulness, satisfaction and human dignity.

As implied by the declaration of policy in the act authorizing the White House Conference, effective efforts cannot be the responsibility of any single agency or group, public or private, or of any one level of government. Communities must recognize the potentials and the needs of older citizens and make an effort to provide an environment in which each one can live the particular type of life best suited to his individual needs and capacities. Programs and policies which tend to impose uniformity should be avoided.

### Important Role of the Community

Thus, the theme of this conference, "What Can The Community Do For Its Older Citizens." The emphasis on the community is, I believe, a realistic one. The community already is a part of an older person's life, just as he is a part of the community. It is only natural that he should seek the fulfillment of his advanced years where he has contributed before—at home. It is to his benefit and to the benefit of the community.

The problems of the aging are not those of building great housing developments or massive hospitals or even a gigantic work camp. They are individual problems, best satisfied through a job, security and health benefits, the individual requirements which allow a person to remain himself.

### Employment and Adequate Income

Basic to the health and happiness of older people is an adequate income. Many of their problems are solved or avoided when jobs suited to their capacities are found. And this is certainly an area where the community and the community employers can be effective, while at the same time solving the shortage in the labor market, which is coming.

Employment, however, is only one problem of the aging. Others, such as health, retirement, community participation, can be solved on one level or another, perhaps through the cooperation of local and federal governments or private agencies.

Almost two years ago, I addressed the Southern Regional Conference on Aging. There I said: "One of the great measures of civilization is the degree to which it is concerned about its weakest members. In the great whirlpool of advance on the various scientific and humanitarian fronts, we have expanded our yardstick of civilization from that of survival of the fittest only, to a new index, that of the survival of the weakest—to insure the survival of all."

### Insuring the 'Survival of All'

Now, I am even more convinced of the truth and rightness of this statement. And one area in which we can do much to insure the survival of all, through helping weaker members of our society, is aging. As we meet today and again a year from now and finally in the White House Conference, we will discuss the problems again and consider possible solutions. These discussions themselves, this growing consciousness of our senior citizens and their needs and potential, is itself a large part of the solution.

The Conference today is a giant step forward towards both understanding and solving the needs of aging. The effectiveness of the Conference will be due to all of you who have been interested enough to attend and to those who have taken their time to plan and participate in the program. I wish you success in your deliberations.

# Special Article

# Prevalent Medical Problems of the Senior Citizens Of West Virginia and Recommended Community Planning and Action for Their Solution*

*N. H. Dyer, M. D., M. P. H.*

TODAY in West Virginia, and the United States, young people are living to become older and the older people are living longer. This situation has developed due to the great progress made by medical science and all health workers in controlling the acute communicable diseases of early life. As a result, the number of persons 65 years or older is increasing rapidly.

In 1947, there were in our state approximately 98,000 individuals 65 years of age and older. Today this number has increased to approximately 160,000 with a predicted annual increase of around 4,000. It is estimated that 25 per cent of these senior citizens need medical care and treatment for chronic illness and about 25 per cent more need health guidance.

### Occurrence of Chronic Illness

Except for the communicable diseases, West Virginia does not have a morbidity reporting system. We are now moving in that direction but we lack data on the occurrences of chronic illness among the older citizens. By accepting the national estimates we can predict that by 1965 there will be in West Virginia approximately 40,000 persons over 65 years of age suffering from some form of heart disease, another 40 thousand with rheumatism and arthritis, and 30 thousand with mental illness.

We should begin at once to formulate our plans and follow up with action, with the object of reducing these estimates by preventing the occurrence and progression of these chronic diseases. Unless we recognize these health problems of the older members of our population and take action to solve them the cost to the state in providing medical care facilities will be too great to contemplate.

*Presented before the Governor's Conference on Aging held at the Capitol in Charleston, September 25, 1959.

Submitted to the Publication Committee, November 6, 1959.

*The Author*

• N. H. Dyer, M. D., M. P. H., State Director of Health, The Capitol, Charleston 5, W. Va.

As the result of our well intentioned efforts we have made it possible for more people to live into the fruitful years of life. These efforts are not enough. We, as citizens, have an obligation to do everything possible to promote the physical, mental and social well being of this increasing group of individuals.

### Care in the Home

We have made available for distribution at this Conference the principal services offered older people by the Health Department and these will not be included in this paper. The basic philosophy of the Health Department for health services for the aging members of the population is that home care should be provided and that permanent hospitalization or institutionalization should be delayed as long as possible.

Let us now consider how we may meet the health needs of our senior citizens through community action. A well organized community group consisting of people with genuine interests and responsibilities in dealing with the health problems of the aging should be established. These community groups could well be affiliated with a larger county committee on aging in order to coordinate county-wide activities. Such community groups should first study the nature and extent of the problem by collecting data on population trends, disease and accident occurrences, availability of home care, home and community environment, nursing home and hospital facilities and the economic status of this age group. When the study has been completed it should be evaluated to determine those problems which are the most urgent, and a plan of action formulated.

**Health Services for the Aging**

I would like to suggest the following objectives for consideration by community, county, and state groups and all voluntary and official agencies providing health services for the aging members of our population:

(1) Work toward the elimination of a specific retirement age. Old age is a normal, gradual process of human life. The age of beginning and the progress of the condition varies with the individual. Mr. Smith may be an old man at 55 while Mrs. Murphy cares for herself nicely and would be offended if she were called old at the age of 75. The story is told about a lady in England over 80 years of age who when asked if she could possibly manage to look after her older sister, said she couldn't. When asked why, she replied that she didn't have the time after working at her regular job in the machine shop. Physical and mental inactivity lead to loneliness, a feeling of rejection, lack of motivation and insecurity resulting in health impairment. The retirement age should be physiologic instead of chronologic.

(2) Promote home care programs for those chronically ill and not requiring immediate hospitalization. Some local health departments in our state are now attempting this service but are handicapped because of a lack of funds and personnel. Community groups can assist materially in this endeavor.

(3) Stimulate an expansion of hospital and nursing home facilities for those too ill or who lack facilities to be cared for in the home. There has been a noticeable expansion of hospital facilities during the past 12 years as the result of the Hill-Burton Construction Program. We need more adequately staffed and equipped nursing homes.

(4) Assist in developing a community educational program to advise the people of their responsibilities in dealing with the health problems of the older citizens.

(5) Seek to obtain and disseminate more information regarding the chronic diseases of the oldsters. This information can be secured from physicians, health departments and other pertinent agencies.

(6) Cooperate closely with official and voluntary health agencies in the advancement of programs for the prevention of the occurrence and progression of disabling diseases of the aged.

(7) Work to strengthen county health departments in order that services may be expanded and private physicians may receive assistance from these departments in providing medical care to meet the needs of this age group.

(8) Keep in mind that the total health of the oldsters must be maintained. We must have a balance of physical, mental and social well-being. This can be accomplished only when there is complete cooperation between all community groups and agencies concerned. By exchanging knowledge and information and stimulating mutual understanding of this great problem among the many forces involved in working with the aged, much can be accomplished.

(9) Assist in setting up community clinics for the purpose of making available facilities to provide information and guidance for the oldsters in meeting their needs for physical and emotional well-being.

I appreciate the opportunity to participate in this Conference. By working together we can improve the well-being of the increasing number of those living in the golden age group of the human life span.

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# Industrial Medical Manpower Shortage

The supply of full-time industrial physicians may suffice some years hence to allow one for every establishment with, say, 2,000 or more employees. The prospect of there being one for every establishment employing as few as 1,000 employees is remote.

As for establishments with still fewer employees, in which over three-fourths of the working people of the country are employed, the occupational health service of many of these will eventually be provided by physicians engaged full-time in industrial medicine, serving several establishments each on a part-time basis. But the occupational health service of the vast majority of such establishments, certainly of those with fewer than 500 employees, will have to be provided by physicians engaged in private practice and doing industrial medicine on a part-time or on-call basis.—B. Dixon Holland, M. D., in Industrial Medicine and Surgery.

# The President's Page

*Guest Author, Mrs. Robert R. Pittman, Marlinton, President,*
*Woman's Auxiliary to the West Virginia*
*State Medical Association*

I wish to thank you, the Doctors of West Virginia, for your kind cooperation. It is an honor to have the privilege of writing this message. I was most happy to accept Dr. J. C. Huffman's invitation to write a brief summary of my observations of the Auxiliary activities over the state.

Since assuming the office of President of the Woman's Auxiliary to the West Virginia State Medical Association, I have had the pleasant privilege of visiting with 12 of our 22 component auxiliaries. It has been a pleasure to observe them in their endeavors to promote better Community Health as they stand side by side with their Doctor husbands. The Auxiliary is the keystone in the arch of Public Relations. The AMA's work will never be finished and neither will that of the Auxiliary.

Auxiliary membership grants many wonderful privileges, but it carries with it a definite responsibility to the Medical Profession. As a Doctor's wife, one can be an important factor in promoting good public relations.

> *"Every man owes some of his time to the upbuilding of the profession to which he belongs."—Theodore Roosevelt.*

Therefore, and in accordance with this wise saying of Theodore Roosevelt, it is the duty of each member to strive to carry out the objectives of the Auxiliary; such as:

(1) To assist the AMA in its program for the advancement of medicine and Public Health, (2) To coordinate and advise concerning the activities of constituent auxiliaries, and (3) To cultivate friendly relations and promote mutual understanding among the families of physicians.

Our 1959-60 goals are as follows and are being most capably carried out by our component auxiliaries:

(1) An increase in Membership, (2) More subscriptions to the National Bulletin, (3) Becoming informed on Legislation, (4) Promoting better Mental Health, (5) A large increase in A.M.E.F. Contributions, and (6) Helping to make our homes and highways safer.

I know you are very much interested in some of the things we are doing in the Auxiliary. The fall months have been busy for all of us as each component auxiliary has taken an active part in becoming better informed on the Forand Bill, "the care of the aging," and public relations. We are bearing in mind, as we renew our efforts this year, that we, as wives of physicians, have a unique responsibility toward community service. We are learning the health needs of the community and sharing this knowledge with others as we take an active part in improving these conditions. The greatest growth comes through knowledge and participation. After visits with many of our component auxiliaries and attendance at several state and out-of-state meetings, I have been most favorably impressed by the necessity of becoming informed in order to guide others in promoting better health.

It has been a privilege and a pleasure to present this message to you. I hope each of you had a nice Christmas—full of health and good cheer. May the best of good fortune be yours in the New Year. May you have success in all your endeavors and may your aims be accomplished, as always.

# THE WEST VIRGINIA MEDICAL JOURNAL

*Official Organ of the West Virginia State Medical Association*

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.



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*Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.*

*Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.*


# EDITORIALS

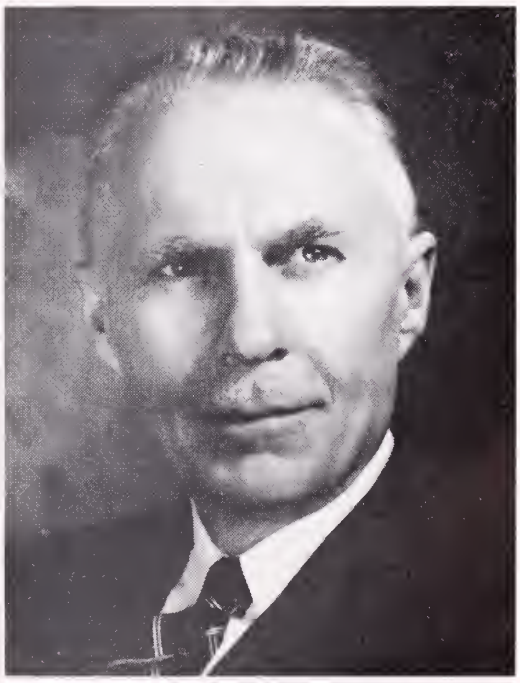
**DR. VAN LIERE, AUTHOR**

Not in many moons have we enjoyed a book more than the volume of essays, *A Doctor Enjoys Sherlock Holmes*, by Dr. Edward J. Van Liere on the medical aspects of the great fictional characters by Dr. A. Conan Doyle, Sherlock Holmes and Doctor Watson. It has been well said that every man views the world through his own goggles, and no one could be better qualified to turn the doctor's goggles on Sherlock Holmes than Doctor Van Liere who holds an A.B. and an M.S. from the University of Wisconsin; an M.D. from Harvard; and a Ph.D. from the University of Chicago.

Since 1921 he has been Professor of Physiology at West Virginia University and for most of that time he has served as Dean of the School of Medicine. His work at Morgantown has been so outstanding that he has left a greater impress upon the medical profession in West Virginia than has any other individual at any time.

For years past, Doctor Van Liere has been a devotee of Sherlock Holmes and has published essays upon the medical aspects of Holmes and his fictional friend, Doctor Watson, several of them in *The Journal*. These are reprinted in the volume and others hitherto unpublished are included.

We welcome their appearance in bound form (Vantage Press, 1959). The medical aspects as presented by Doctor Doyle are made more realistic by the manner in which Doctor Van Liere has intertwined them with medicine of Doyle's day and that of our own era, and with the way he weaves in science generally. The style is not only lucid, but very interesting. In fact we may describe it as pleasing.



Edward J. Van Liere, M. D.

A former volume by Doctor Van Liere, *Anoxia: Its Effect On The Body*, was purely scientific. This book was the last word upon that subject when it was published 16 years ago, and we know of no work surpassing it since.

Doctor Van Liere has asked to be relieved of the Deanship at Morgantown at the end of the current scholastic year so that he may devote all his time to teaching his specialty of physiology. We trust he finds time to continue writing for which he is so well suited both from a standpoint of natural aptitude and that of a very broad general education.

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**WILL E. NEAL, M. D.**

Again the fell scythe of the Grim Reaper has struck down one of our oldest, staunchest, and most beloved members. On November 12, Will E. Neal was called from labor unto rest. Born in Lawrence County, Ohio, October 14, 1875, he had just completed his eighty-fourth year of life. He was christened William Elmer Neal, but chose to sign himself Will E. Neal. He was educated at Ohio Northern College where he received the A.B. degree in 1901, and at the Medical College of Ohio, now the Medical Department of the University of Cincinnati, where he graduated as a doctor of medicine in 1906.

After a year's internship at the Good Samaritan Hospital in Cincinnati, he located in Huntington where he practiced general medicine actively for forty-five years. Always interested in community betterment, he served one term as Mayor, for many years on the Park Board, two terms in the State Legislature, and two terms as Member of Congress from the Fourth District.

A lifelong Methodist, more than half a century a Master Mason, and a staunch Republican, Will Neal was ever in the forefront of the fight for community advancement. He was always able to see the other side of a question and had the rare ability to decide upon what he considered to be the greatest good to the greatest number, hew to that line, and let the chips fall wherever they might. More than four decades of close association with him as a physician and as a close personal friend taught us to respect him as a man, as a physician, as a citizen, and as a Christian gentleman. His work and his deeds were such that we may aptly describe him in the language of the immortal Bard of Avon:

*"His life was gentle, and the elements*
*So mixed in him that Nature might stand up*
*And say to all the world, 'This was a man!'"*

**COST BUT LITTLE—HELP A LOT**

Almost as soon as it opened the Senate subcommittee hearing on problems of the aged broke down into the familiar arguments. Everyone could and did agree on the bare facts of the problem: For a number of reaons, all of them salutary, people are living longer and longer. In West Virginia, for example, where the population as a whole has increased only two per cent in nearly 10 years, the number of those over 65 has gone up 20 per cent.

Beyond this the differences of opinion on what to do about it broaden into a yawning gap. Rep. Bailey is all for turning the whole problem over to the federal government and making the aged the sole responsibility of the federal government. It and presumably it alone would have the awesome responsibility of meeting their total requirements for food, clothing, shelter and medical care.

Gov. Underwood, the medical profession, and the farmers resisted this suggestion on several grounds and held out the hope, at least, that within private means and local action there is another way.

Out of this came one suggestion from Sen. Randolph which offers something a little more concrete. It is to liberalize what the beneficiaries of social security may earn without sacrifice to their benefits. Under the present law these limits exert a cruel hardship on many of the aged. They cannot live on their social security. But if they try to supplement their income by continuing to work, they are penalized for almost every additional dollar.

This condemns many of them to a genteel poverty and forces some of them into a frustrating idleness. They have earned their social security, but if they claim it, they must surrender their right to hold a job they are fully capable of performing. It is a cruel and shortsighted arrangement, and it could be corrected without any great cost to the social security program and at a considerable gain to the welfare of the aged.—*Charleston Daily Mail.*

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**The Price of Socialism**

Great Britain's program of socialized medicine is getting costlier every year. In the 10 years since medicine was nationalized, the Minister of Health reports the annual cost of the program has jumped from 1.25 billion dollars to more than 2 billion for a nation of about 51 million people. Of the current bill, patients pay less than 20 per cent, with roughly 80 per cent coming out of general tax funds in the British Exchequer.—West Virginia Farm News.

# GENERAL NEWS

## Council Acts Upon Important Matters At Final Meeting of the Year

Compensation Commissioner Charles N. Straughan, of Charleston, was a guest at the fall meeting of the Council held at the Chancellor Hotel in Parkersburg on November 22, 1959. He was present at the invitation of the chairman for the purpose of discussing the matter of the reimbursement of hospitals at cost for in-patient services and such reimbursement for out-patient care on a per-patient basis.

It was explained by the chairman, Dr. George F. Evans of Clarksburg, that under an agreement entered into by the Workmen's Compensation Fund and the West Virginia Hospital Association, it was stipulated that if the hospitals were to be reimbursed at cost for in-patient services, it must follow that reimbursement at cost should also apply to out-patient care on a per-patient basis.

Commissioner Straughan explained that after the final draft of the agreement was completed the Board of Trustees of the West Virginia Hospital Association approved the arrangement with the proviso that the West Virginia State Medical Association approve reimbursement at cost for out-patient services.

Following discussion by several members of the Council, it was ordered that Dr. John E. Lutz, subchairman of a group from the Medical Economics Committee, be directed to continue negotiations with Commissioner Straughan and report at the winter meeting of the Council.

### Medicare Contract Renewed

Dr. James S. Klumpp, chairman of the Medical Economics Committee, submitted a detailed report concerning matters discussed and acted upon at a meeting held in Parkersburg on November 21.

Following the recommendation of the Committee, the Council directed that the present contract with the Office for Dependents' Medical Care (Medicare) be renewed for the period from December 1, 1959, through November 30, 1960.

### Medical and Hospital Care for the Aged

Doctor Klumpp also reported that the members of the sub-committees concerned with Blue Cross-Blue Shield and "third party" plans will seek a conference with state Blue Cross-Blue Shield plans, the State Hospital Association, and representatives of "third party" plans in an effort to agree upon some definite constructive means of providing "pre-paid medical and hospital care for citizens past 65 years of age who are subsisting on minimal incomes from personal resources or retirement or pension plans." He said that the Committee hopes to have such a program developed so that report may be made to the Council at the winter meeting in 1960.

### Revision of DPA Fees Under Study

Following the recommendation of the Committee, action on the resolution offered in the House of Delegates by the Harrison County Medical Society at the annual meeting in August, 1959, was deferred until the winter meeting of the Council. The resolution called for a complete revision of DPA fees.

### Appointment of M. D.'s on DPA Councils

Doctor Klumpp also reported that the Medical Economics Committee had approved a recommendation from the Central West Virginia Medical Society that each county council of the DPA include a member who is a doctor of medicine. The recommendation was approved with the understanding that the doctor of medicine on each DPA county council be appointed by the Governor.

### Local Press-Radio-TV Conferences

Approval was also given to the recommendation of the Medical Economics Committee that positive steps be taken by each component society to "further good public relations through the press, radio and TV by arranging programs on a county and city basis." It was ordered that the proposal be brought to the atten-

New members of the Council of the West Virginia State Medical Association are shown at the meeting held in Parkersburg on November 22. Left to right, Drs. Albert C. Esposito, Huntington, Clyde A. Smith, Beckley, Richard E. Flood, Weirton, and J. C. Pickett, Morgantown.

tion of each component society with the request for its acceptance. The active cooperation of the State Medical Association's Public Service Committee is to be requested in connection with the program suggested for adoption by component societies.

### Honorary Members Elected

The following physicians were elected to honorary life membership in the West Virginia State Medical Association:

| *Society* | *Physician* | *Address* |
|---|---|---|
| Kanawha | Martin L. Bonar | Charleston |
| | H. H. Fisher | Ft. Lauderdale, Fla. |
| Raleigh | L. M. Halloran | Beckley |
| Ohio | D. A. MacGregor | Wheeling |
| | C. Glen McCoy | Elm Grove |
| | R. H. Lewellyn | Elm Grove |

### Dr. Sheppe Renamed to Publication Committee

Dr. William M. Sheppe of Wheeling was reelected a member of the Publication Committee for the seven-year term ending December 31, 1966.

### Cancer Detection Examinations

The Council considered a report submitted by Dr. J. C. Huffman for Dr. Hu C. Myers, Chairman of the Committee on Cancer, who was unable to be present.

In the report, the Council was asked to consider the advisability of the compilation by each component society of a list of physicians who would be willing to give cancer detection examinations. The list would be broken down so as to show physicians willing to give complete examinations and those who would limit such examinations.

The recommendations embodied in the report of the Cancer Committee were approved.

### Licensure of Foreign Graduates

The Legislative Committee was directed to undertake a study of the licensure of foreign graduates with a view to the preparation of factual information for dissemination among the members of the Legislature and the members of the medical profession.

### Part of Dues Earmarked for Scholarships

The Council formally directed that the sum of $3.00 from the 1960 dues of each member be earmarked for Medical Scholarships.

### Miscellaneous

It was ordered that a special committee be appointed to seek a conference with Governor Cecil H. Underwood for the consideration of matters pertaining to problems of the aging.

The Council also directed that a statement be prepared concerning the Forand Bill and that copies be mailed to component societies and local auxiliaries throughout the state.

### New Members Introduced

The following members of the Council elected at the annual meeting at The Greenbrier in White Sulphur Springs in August, 1959, were introduced by the Chairman: Richard E. Flood, J. C. Pickett, A. C. Esposito and Clyde A. Smith.

**A guest at the Council meeting held in Parkersburg on November 22 was Charles N. Straughan, center, State Workmen's Compensation Commissioner. Shown with him are Dr. John Lutz of Charleston, left, and Dr. James S. Klumpp of Huntington.**

Dr. John W. Hash and Dr. D. E. Greeneltch were introduced as the president elect and vice president, respectively.

Besides these members, the meeting was attended by the following: Dr. George F. Evans, Clarksburg, Chairman; Dr. J. C. Huffman, Buckhannon, President; and Drs. Seigle W. Parks, Fairmont; S. Elizabeth McFetridge, Shepherdstown; L. E. Neal, Clarksburg; C. R. Davisson, Weston; Charles L. Goodhand, Parkersburg; William L. Cooke, Charleston; and Mr. Charles Lively, executive secretary and Mr. William H. Lively, executive assistant, both of Charleston.

Also attending the meeting were Dr. James S. Klumpp, of Huntington, Chairman of the Medical Economics Committee; Dr. F. J. Holroyd of Princeton, AMA Delegate and Chairman of the Legislative Committee; Dr. N. H. Dyer of Charleston, State Director of Health; Drs. John E. Lutz of Charleston and J. D. H. Wilson of Clarksburg, members of the Medical Economics Committee; and Drs. Eugene A. Cooper and Charles K. Rath of Logan, members of the Logan County Medical Society.

## Fairmont Radio Station To Present Programs on Medical Center

A series of three radio programs concerning the West Virginia University Medical Center will be presented during the month of January by Station WMMN in Fairmont.

The broadcasts will be sponsored by the Junior League of Fairmont, in cooperation with the Medical Center. The purpose of the programs is to provide the public with information about the teaching and research programs, together with patient care at the Teaching Hospital.

The programs will be presented on the following three Sunday afternoons: January 3, 10 and 17. Broadcast time will be 4:30 P.M.

## Harrison Society Plans Observance Of 'West Virginia Day' on Feb. 4

Elaborate plans are being made by the Harrison County Medical Society for the observance of "West Virginia Day" on February 4, 1960. The program as agreed upon includes a meeting of the WVU Liaison Committee at the Stonewall Jackson Hotel at 3 P. M. Dr. E. J. Van Liere, Dean of the School of Medicine, and Dr. Clark K. Sleeth, Assistant to the Dean, and heads of the various departments of the school are expected to be present.

A social hour has been arranged for the period preceding the scientific program and members of the Woman's Auxiliary to the Harrison County Society will be guests at that time.

Dr. T. Walley Williams, professor of the department of microscopic anatomy at the University Medical Center will be the first speaker at the evening session. His subject will be "A New Concept and Approach to The Teaching of Sub-Macroscopic Anatomy at the West Virginia University Medical Center."

Dr. Kenneth E. Penrod, vice president in charge of medical affairs at the University, will follow Doctor Williams on the program. He will discuss plans for the staffing and operation of the Medical School, with special emphasis on the clinical part of the program.

There will be a social hour immediately following the scientific program that has been arranged for the evening session.

Dr. Elvis J. Stahr, Jr., president of the University, Dr. Thomas L. Harris of Parkersburg, chairman of the Board of Governors, and Dr. Frank J. Zsoldos of Pineville, member of the Board, have been invited to attend the meeting. Dr. J. C. Huffman, president of the West Virginia State Medical Association, will attend the meeting of the Liaison Committee as well as the scientific sessions.

An invitation to join in the observance of "West Virginia Day" is being extended by the Harrison County Medical Society to members of adjoining and adjacent medical societies. Members of the WVU Alumni Association are invited to attend, and it has been made clear that members of the West Virginia State Medical Association generally are invited to be present.

The members of the Harrison County Medical Society are using this means of establishing a closer relationship and understanding with those responsible for the maintenance and operation of the new Medical Center at West Virginia University.

Physicians who expect to attend the meeting are requested to communicate with Dr. R. T. Humphries, Program Chairman, 414 West Main Street, Clarksburg.

## Winter Meeting of MLB, Jan. 11-13

The winter meeting of the Medical Licensing Board will be held at the new State Office Building in Charleston, January 11-13, 1960, for the purpose of examining applicants for licensure to practice in West Virginia.

## Eugene L. Staples Named Director Of WVU Teaching Hospital

Eugene L. Staples of Minneapolis, Minnesota, has been appointed director of the Teaching Hospital at the West Virginia University Medical Center. The appointment, which is effective January 1, 1960, was announced by President Elvis J. Stahr, Jr.

Eugene L. Staples

He has been serving as assistant director of the University of Minnesota Hospitals, where he has been a member of the administrative staff since 1952. His initial responsibilities at the Medical Center will consist of staffing and equipping the new Teaching Hospital.

Mr. Staples received an A.B. degree from the University of Minnesota in 1950 and a master's in hospital administration two years later. He served with the Naval Medical Corps during World War II.

Following his graduation, he accepted a position as administrative assistant at University Hospitals. In 1953 he became assistant to the director in charge of admissions and two years later was named fiscal officer and out-patient department manager, as well as assistant director of University Hospitals.

In 1957, Mr. Staples was also placed in charge of the building, staffing and operation of the Masonic Memorial Hospital, which was opened in October, 1958, as part of the Minnesota Medical Center and which is used for the care of advanced cancer patients.

The new director is a member of the American College of Hospital Administrators. He is married and the father of a six-year-old daughter.

## Narcotics Agent William V. McDonald Retires After 30 Years' Service

Mr. William V. McDonald, who has served for more than 30 years as a federal agent connected with the Bureau of Narcotics, retired on November 30, 1959. He has maintained headquarters in Charleston under the office of the district supervisor, District No. 5, which is composed of the states of Maryland, Virginia, West Virginia, District of Columbia and North Carolina.

The district supervisor, Mr. Irwin I. Greenfeld, of Baltimore, has announced that plans are being made to have an agent in Charleston for a period of time each month, but the exact time when he will be in his office in that city has not yet been determined.

Pending completion of plans for the location of an agent in West Virginia, correspondence regarding narcotics should be addressed to Mr. Irwin I. Greenfeld, District Supervisor, Bureau of Narcotics, Baltimore 2, Maryland.

## Proceedings of AMA Clinical Meeting In Dallas, December 1-4

More than 4,500 persons attended the 13th annual Clinical Meeting of the American Medical Association in Dallas, Texas, December 1-4. The total registration at the end of the third day of the meeting, with a half day still to go, had reached 4,727, including 2,742 physicians.

All sessions of the House of Delegates were held at the Adolphus Hotel. Scientific sessions were held and color TV programs shown at Dallas Memorial Auditorium. Scientific and technical exhibits were also set up in Convention Hall.

### State Physicians Active at Meeting

Dr. Frank J. Holroyd of Princeton and Dr. Charles A. Hoffman of Huntington, AMA delegates from West Virginia, attended the meeting and were present for all sessions of the House of Delegates. Doctor Hoffman was appointed by the Speaker, Dr. Norman A. Welch

**Dr. Charles A. Hoffman of Huntington, AMA delegate from West Virginia, is shown with Dr. W. Vinson Pierce of Covington, Kentucky, during a session of the House of Delegates. Doctor Pierce is a delegate from Kentucky.**

of Boston, as one of five tellers to serve during the two sessions of the House.

Doctor Holroyd, who is secretary-treasurer of the Aces and Deuces, was in charge of arrangements for that organization's annual luncheon for members of the House of Delegates.

More than 225 persons attended the luncheon which was held on Wednesday, December 2. The Aces and Deuces is a social organization composed of AMA delegates from State Medical Associations and Societies which have one or two members in the House of Delegates.

Dr. Walter E. Vest of Huntington, a former member of the House of Delegates, was present at the convention and attended all meetings of the Council on Constitution and By-Laws, of which he is a member.

One of the scientific exhibits in the Auditorium, "Anti-Inflammatory Adrenocorticoids," was arranged and presented by three members of the staff at the Veterans Administration Hospital in Martinsburg, Drs. Thomas H. McGavack, Hans G. Bauer, and Kung-Ying Tang Kao.

### Proceedings of Clinical Meeting

The following summary of the Dallas meeting was prepared by Dr. F. J. L. Blasingame, executive vice president of the American Medical Association:

Freedom of choice of physician, relations between physicians and hospitals, a scholarship program for deserving medical students and relative value studies of medical services were among the major subjects acted upon by the House of Delegates at the Clinical Meeting in Dallas.

Dr. Chesley M. Martin of Elgin, Oklahoma, was named as the 1959 "General Practitioner of the Year" for his outstanding contributions to the health and civic affairs of his home community. Doctor Martin, who has practiced in Elgin for the past 44 years, was the 13th recipient of the annual award and the first Oklahoman to be so honored.

Speaking at the opening session of the House on Tuesday, December 1, Dr. Louis M. Orr of Orlando, Florida, AMA President, urged the nation's physicians to take a more active interest in the whole area of politics, public affairs and community life. Doctor Orr also asked physicians and medical societies to do a more effective job of telling medicine's positive story, adding that "if more people knew more about the things we support and encourage, they would listen to us much more carefully about those occasional things that we oppose."

### Addresses by Johnson and Rayburn

Two nationally known political leaders from Texas also addressed the Tuesday morning session. Senator Lyndon B. Johnson, majority leader in the U. S. Senate, called for a "politics of unity" which will enable Americans to exert strength and determination in an effort to create a world in which all men can be free. Speaker of the U. S. House of Representatives Sam Rayburn urged greater attention to the task of educating young people in the principles of American government and giving them a desire to perpetuate it.

### Freedom of Choice

In considering four resolutions which in various ways would have changed or replaced the statements on freedom of choice of physician which the House adopted in June, 1959, when acting upon the recommendations in the report of the Commission on Medical Care Plans, the House reaffirmed the following two statements approved in Atlantic City:

1. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses."

2. "Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

However, in order to clarify and strengthen its position on the issue of freedom of choice of physician, the

House also adopted this additional statement which was submitted as a substitute amendment on the floor of the House:

3. "Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

### Physician-Hospital Relations

The House received 12 resolutions on the subject of relationships between physicians and hospitals. To resolve any doubt about its position, the House did not act upon any of the resolutions but instead reaffirmed the 1951 "Guides for Conduct of Physicians in Relationships with Institutions." It also declared that "all subsequent or inconsistent actions are considered superseded."

The House also accepted recommendations that (1) the House of Delegates acknowledge the need to strengthen relationships with hospitals by action at state and local levels, (2) the Board of Trustees of the Association continue to maintain liaison with the Board of Trustees of the American Hospital Association, and (3) the Council on Medical Service review this entire problem to ascertain if there have been actions inconsistent with the 1951 Guides.

Those Guides summarize the following general principles as a basis for adjusting controversies:

"1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

"2. Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

"3. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine."

### Scholarship Program

To help meet the need for an increasing number of physicians in the future, the House approved the creation of a special study committee which was asked to:

1. Present a scholarship program, its development, administration and the role of the American Medical Association in fulfilling it.

2. Ascertain the maximum to which medical schools could expand their student bodies while maintaining the quality of medical education.

3. Ascertain what universities can support new medical schools with qualified students and sufficient clinical material for teaching—either on a two year or a full four year basis.

4. Investigate the securing of competent medical faculties.

5. Investigate financing of expansion and establishment of medical schools.

6. Investigate financing of medical education as to the most economical methods of obtaining high quality medical training.

7. Develop methods of getting well-qualified students to undertake the study of medicine.

**Shown together at the Aces and Deuces luncheon held during the AMA Clinical Meeting in Dallas last month are, left to right, Dr. Frank J. Holroyd of Princeton, AMA delegate from West Virginia; Emil Pollard of Ann Arbor, Michigan, and Thomas R. Turner of Galveston, Texas, delegates from the Student American Medical Association; and Dr. Wesley W. Hall of Reno, Nevada, delegate from that state. Doctor Hall is president of the Aces and Deuces organization, and Doctor Holroyd is secretary.**

8. Investigate the possibility of relaxing rigid geographic restrictions on the admission of students to medical schools.

The House urged that the special committee be implemented promptly with adequate funds and staff so that it may make an initial report by June, 1960.

### Relative Value Studies

Reaffirming a previous policy statement, the House approved in principle the conducting of relative value studies by each state medical society, rather than a nationwide study or a series of regional studies by the AMA. The House also reiterated its authorization for the Committee on Medical Practices to inform each state medical association, through regional or other meetings, of the purpose, scope and objectives of such studies, the steps to be followed in conducting studies, the problems which may be encountered and the manner in which the results can be applied.

The House recognized, however, that some state medical societies are either not interested in relative value studies or are actively opposed to them. It pointed out that some state medical associations fear that the regional conferences of the Committee on Medical Practices will put pressure on them to carry out such studies and that this will result in the adoption of "fixed fees."

Since the regional conferences are educational in nature, the House said, it remains for each state or county medical association to accept or reject the idea of a study in its area.

The House expressed awareness of the fact that this is still a controversial matter. However, it commended the Committee on Medical Practices for its effort to carry out the instructions of the House, and it urged the committee to continue its educational work.

### Miscellaneous Actions

In considering 44 resolutions and a large volume of annual, supplementary and special reports, the House also:

Learned that the AMA Board of Trustees has appointed a liaison committee to meet with a similar committee of the American Osteopathic Association to consider matters of common concern;

Emphasized that local medical societies should insure that no member violates ethical traditions as they relate to ownership of pharmacies or stock in pharmaceutical companies;

Approved the plan of the Committee on Medical Rating of Physical Impairment to publish its new guide on the cardiovascular system in the *JAMA*.

Recommended that Association councils and committees, whenever feasible, hold their meetings in the remodeled Chicago headquarters;

Called for investigation of the need, desirability and feasibility of establishing a home for aged and retired physicians;

Commended Dr. F. S. Crockett, retiring chairman of the Council on Rural Health, for his many years of devoted duty;

Urged active promotion and careful study of the newly developed "Guides for Medical Care in Nursing Homes and Related Facilities";

Suggested that fees for consultative examinations under programs of the Bureau of Old Age and Survivors Insurance should be adjudicated directly between the state medical society and the state agency involved;

Registered a strong protest to the Veterans Administration, urging stricter screening of non-service-connected disability patients admitted to government hospitals;

Reiterated the Association's support of the Blue Shield concept and directed the Council on Medical Service to submit at the June, 1960, meeting its recommendations concerning a policy statement on AMA relationship with Blue Shield plans;

Suggested that S.J. Res. 41, a bill which would institute a separate program of international medical research, be delayed until an over-all assessment can be made of proposals now before Congress dealing with domestic and international medical research;

Endorsed the program of the Educational Council for Foreign Medical Graduates but also urged that judicious consideration be given to local problems involved in the July 1, 1960, deadline for certification of foreign graduates;

Urged that medical schools include in their curricula a course on the social, political and economic aspects of medicine;

Declared that the threat of nuclear warfare has imposed a tremendous responsibility on the medical profession, which must be prepared to assume a critically important role in such an event;

Suggested that the AMA make available to school libraries information and literature showing the advantages of private medical care and the American free enterprise system;

Stated that examinations to determine the physical and mental fitness of aircraft crew members should be made by doctors of medicine with special knowledge and proficiency in certain techniques;

Urged the American people to get proper tetanus toxoid, original and booster, and other immunizations as indicated from their physicians, and called on AMA members to cooperate in an educational program on tetanus immunization;

Recommended that all state and county medical societies establish programs for the inspection and testing of all fluoroscopes and radiographic equipment;

Approved the Speaker's proposal that the opening session of the House, at the Interim Meeting, be moved from Tuesday morning to Monday morning, with the reference committees meeting on Tuesday and the House reconvening on Wednesday afternoon;

Called upon each individual physician to wage "a vigorous, dynamic and uncompromising fight" against the Forand type of legislation;

Urged state and local medical societies and individual physicians to implement the AMA program for recruitment of high-grade medical students;

Accepted with appreciation a $2,500 contribution by Smith, Kline and French Laboratories toward establishment of a suitable award honoring Dr. Thomas G. Hull, retiring secretary of the Council on Scientific Assembly; and

Reaffirmed the "Suggested Guides to Relations Between Medical Societies and Voluntary Health Agencies," which were adopted at the December, 1957, meeting in Philadelphia.

At the Tuesday opening session, six state medical societies presented nearly $250,000 to the American Medical Education Foundation. The checks turned over to Dr. George F. Lull, president of AMEF, were: California, $156,562; Indiana, $35,570; New York, $19,546; Utah, $10,355; New Jersey, $10,000, and Arizona, $9,263.

## Medical Meetings, 1960

The following is a partial list of national, state and district medical meetings scheduled for 1960:

Jan. 11-13—MLB, Charleston.
Jan. 21-23—ACS Sectional Meeting, Louisville, Ky.
Feb. 4—"West Virginia Day" Observance, Clarksburg.
Feb. 28-Mar. 4—Am. Coll. of Allergists, Bal Harbour, Miami Beach, Fla.
Mar. 20-24—American Academy of General Practice, Philadelphia.
Apr. 1-2—W. Va. Chap., ACS, White Sulphur Springs.
Apr. 4-8—ACP, San Francisco.
Apr. 10-12—W. Va. Acad. Oph. & Otol., White Sulphur Springs.
Apr. 29-30—W. Va. State Society of Technologists, Charleston.
May 6-8—W. Va. Chap. AAGP, Charleston.
June 13-17—AMA Annual Meeting, Miami Beach, Fla.
**Aug. 25-27—93rd Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.**
Sept. 13-15—National Cancer Conf., Minneapolis.
Sept. 14-16—Southern Trudeau Soc., Charleston, S. C.
Sept. 22-24—W. Va. Hospital Assn., White Sul. Springs.
Oct. 21-23—PG Institute, Martinsburg.
Nov. 29-Dec. 2 — AMA Clinical Meeting, Washington, D. C.

### Auto Emblems Available

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

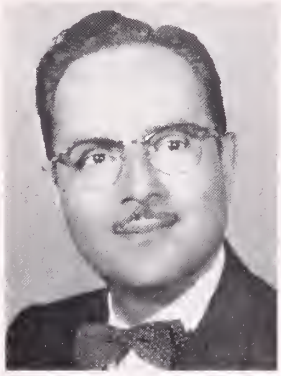
## Medical Treatment Now Provided At Rehabilitation Center

Dr. John P. Brick of Charleston, physician for the State Rehabilitation Center at Institute, has announced that a medical treatment center has been added and is now functioning. It is planned to have a visiting day for physicians at sometime in the near future; however, a cordial invitation has been extended by Doctor Brick to all physicians to visit the center at any time that might suit their convenience.

Doctor Brick will on January 1 assume additional duties as plant physician at the South Charleston plant of Westvaco Chlor-Alkali Division of the Food Machinery and Chemical Corporation.

## Dr. Albert C. Esposito Honored By Southern Medical Assn.

Dr. Albert C. Esposito of Huntington was elected secretary of the Section on Ophthalmology and Otolaryngology of the Southern Medical Association during the annual meeting in Atlanta, Georgia, November 16-19.


Albert C. Esposito, M. D.

He and Dr. Walter E. Vest, also of Huntington, were appointed associate councilors for West Virginia during the meeting. The councilor is Dr. Howard A. Swart of Charleston.

Dr. Tom D. Spies of Birmingham, Alabama, was named president elect of the Association and will be installed at the next annual meeting in St. Louis. He will succeed Dr. Edwin H. Lawson of New Orleans, who was installed in Atlanta.

Other new officers include Dr. A. Clayton McCarty of Louisville, Kentucky, first vice president, and Dr. Jack C. Norris of Atlanta, second vice president.

Mr. V. O. Foster continues as Executive Secretary-Treasurer and Managing Editor, and Mr. Robert F. Butts as Business Manager and Associate Executive Secretary and Treasurer. Mr. C. P. Loranz was renamed Advisor and Special Consultant and Dr. R. H. Kampmeier of the Vanderbilt University School of Medicine at Nashville, continues as editor of the *Southern Medical Journal.*

Doctor Spies was awarded the Seale Harris Award for his research accomplishments in the field of metabolism, endocrinology and nutrition. He is the first recipient of the medal, named in honor of the late president of the Association.

The Distinguished Service Award for outstanding contributions to the advancement of medical science was presented to Dr. Robert L. Sanders of Memphis, Tennessee, a past president of the Association.

## Minter B. Ralston Heads Pharmacists

Minter B. Ralston, II, of Weston, has been elected president of the West Virginia Pharmaceutical Association and will be installed at the annual meeting at The Greenbrier in White Sulphur Springs, in August 1960. He is currently serving as first vice president of the organization.

## 1960 Southern Trudeau Society Meeting

The 1960 annual meeting of the Southern Trudeau Society and the Southern Tuberculosis Conference will be held at the Hotel Francis Marion in Charleston, South Carolina, September 14-16.

Further information may be obtained by writing to Judson M. Allred, Jr., Secretary, Box 9865, Northside Station, Jackson, Mississippi.

## Mr. Edward R. Loveland Retires As ACP Executive Secretary

Mr. Edward R. Loveland of Philadelphia, who has served for 34 years as executive secretary for the American College of Physicians, has tendered his resignation effective December 31, 1959.

He will be succeeded by Dr. Edward C. Rosenow, Jr., of Los Angeles, California, now executive director of the Los Angeles County Medical Association.

Mr. Loveland accepted appointment as executive secretary of the ACP on April 4, 1926. At the annual session in Los Angeles in 1956, he was elected an Honorary Fellow of the College, the first and only person other than a physician to be so honored. About the same time he was elected to membership in the honorary medical society, Alpha Omega Alpha, an added recognition of his influence upon American medical education.

Doctor Rosenow, while serving as executive director of the Los Angeles County Medical Association, continued as clinical professor of medicine at the University of Southern California, the University of California School of Medicine at Los Angeles, and the College of Medical Evangelists.

He is a Diplomate of the American Board of Internal Medicine and has been a Fellow of the American College of Physicians since 1942. He has served as president of the Los Angeles Society of Internal Medicine, the Los Angeles Heart Association and the Los Angeles County Medical Association.

## Stoneburner Lectures To Be Held In Richmond, March 16-19

The 1960 Stoneburner Lectures, sponsored by the School of Medicine of the Medical College of Virginia and the Alumni Association, will be held in Richmond, March 16-19.

The program is presented annually in memory of Dr. L. T. Stoneburner, Jr., an alumnus of the College, who was lost in a flight over the Mediterranean during World War II.

The first presentation will be at 8:30 P.M., March 16, and will be delivered by Dr. Joseph A. Bunim, Clinical Director, Section of Arthritis, National Institutes of Health, Bethesda, Maryland.

Further information concerning the program may be obtained by writing to the Alumni Association of the Medical College of Virginia, Richmond.

## Cancer Conference in Minneapolis

The Fourth National Cancer Conference, sponsored by the American Cancer Society and the National Cancer Institute, will be held in Minneapolis, September 13-15.

Further information concerning the program may be obtained by writing to the coordinator, Roald N. Grant, M.D., American Cancer Society, Inc., Medical Affairs Department, 525 West 57th Street, New York 1, New York.

## Various Health Problems Subject Of New ABC Radio Program

"Highroad to Health" is the title of a new series of radio programs begun last month over the nationwide network of the American Broadcasting Company. The series is under the supervision of the American Medical Association and is being presented by ABC in cooperation with Lederle Laboratories, a Division of American Cyanamid Company.

Weekly programs of 15 minutes each will deal with a wide range of health problems from the careless household accidents to the burdens created by chronic illness.

Each program will open with a nine-minute dramatization of a health problem. This will be followed by a five-minute discussion of the problem by a guest physician who will also answer questions posed by the program host.

### Proposed Constitutional Amendment

The following amendment to the Constitution of the West Virginia State Medical Association offered at the 92nd Annual Meeting at the Greenbrier in White Sulphur Springs, August 20-22, 1959, by James S. Klumpp, M. D., of Huntington, Chairman of the Committee on Constitution and By-Laws, will be acted upon finally by the House of Delegates at the 93rd Annual Meeting at The Greenbrier, August 25-27, 1960:

**Art. V**

Sec. 1. Amend the section by adding at the end thereof the following: "and (4) one delegate from each section and affiliated association and society which has been accepted and approved by the Council."

(The effect of the amendment would be to expand the membership in the House of Delegates so as to include a delegate from each Council-approved section and affiliated association and society).

## New Film on Medical Assistants Available for Showings

The key role played by the physician's medical assistant in creating good public relations is emphasized in a new film now available for showings to medical societies and medical assistants groups.

Entitled "First Contact," the 26-minute color film shows the mistakes a new office assistant can make unless she is properly trained for her job and points out that medical assistants groups provide opportunities for increasing on-the-job efficiency.

The film was produced by Wyeth Laboratories for the American Association of Medical Assistants in cooperation with the American Medical Association. Prints of the 16 mm film may be obtained by writing directly to the Wyeth Film Library, Box 8299, Philadelphia 1, Pennsylvania.

## Institute on Back Injuries Planned In Cleveland, Feb. 12-13

A two-day Institute on "The Back: A Law-Medicine Problem Reappraised," will be conducted by the Law-Medicine Center of Western Reserve University in Cleveland, Ohio, February 12-13.

A special feature of the Institute will be two actual settlement negotiations in the Saturday afternoon session, one involving a whiplash case and the other a disc case.

The Institute will be held in the Hatch Auditorium of the Newton D. Baker Building on the Western Reserve University Campus. The registration fee is $25.00, and housing facilities will be available.

Further information may be obtained by writing Oliver Schroeder Jr., Law-Medicine Center, Western Reserve University, Cleveland, Ohio.

## Annual AAGP Scientific Assembly In Philadelphia, Mar. 21-24

The Twelfth Annual Scientific Assembly of the American Academy of General Practice will be held in Philadelphia, March 21-24. More than 7,000 persons, including 4,000 physicians, are expected to attend the four-day meeting which will highlight recent progress in medicine and surgery.

Scientific sessions will be held at Convention Hall and the Congress of Delegates, policy-making body of the organization, will hold its sessions at the Bellevue-Stratford Hotel.

More than 30 prominent medical educators will appear as guest speakers and will discuss a variety of subjects ranging from arthritis and anemia to surgery, geriatrics and mental health. Approximately 100 scientific and 300 technical exhibits will be shown throughout the meeting.

### Change in Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston 24, West Virginia.

## Society of American Bacteriologists To Meet in Philadelphia

The 60th Annual Meeting of the Society of American Bacteriologists will be held at the Bellevue-Stratford Hotel in Philadelphia, May 1-5, 1960. More than 450 papers concerning the latest research findings in bacteriology and microbiology will be presented during the five-day meeting.

Dr. Harry E. Morton of Philadelphia, professor of bacteriology at the University of Pennsylvania School of Medicine, will be chairman of the meeting and he has said that a minimum of seven sessions would be held simultaneously in three mid-Philadelphia Hotels.

## 1960 Session of Legislature To Convene on Jan. 13

The 1960 session of the West Virginia Legislature will be convened at The Capitol in Charleston on Wednesday, January 13. The session will last 30 days.

Under the law the sessions in even-numbered years are limited to consideration and approval of the budget bill. Governor Underwood may, however, include other matters in the call, or such action could be taken by a two-thirds vote of the members.

The headquarters offices of the State Medical Association in Charleston will prepare and mail Legislative Bulletins to the entire membership during the session. News of legislative proceedings will also be carried in future issues of *The West Virginia Medical Journal.*

### Relocations

Dr. Ralph D. Lausa, formerly of Man, is now serving a residency in obstetrics and gynecology at the Cleveland Clinic. His home address there is 3523 Woodridge Road, Cleveland Heights, Ohio.

* * * *

Dr. George Miley Solan of Sharples has moved to Romney where he will continue in general practice, with offices at 290 North High.

* * * *

Dr. Don F. Hatten of Man has moved to Pt. Pleasant where he is serving as chief of obstetrics and gynecology at the new Pleasant Valley Hospital in that city. He is also a member of the staff of the Gallipolis Clinic in Gallipolis, Ohio. His home address in Pt. Pleasant is 1203 Meadow Brook Drive.

* * * *

Dr. Charles A. Stump, formerly of Grantsville, is now serving as chief resident and instructor in the Department of Obstetrics and Gynecology at the University of Florida College of Medicine. The residency is for a period of two years.

He completed a second tour of duty in the Navy in 1958, being released with the rank of Lieutenant Senior Grade.

## 3rd Int. Cong., Physical Medicine In Washington, Aug. 21-26

The Third International Congress of Physical Medicine will be held at the Mayflower Hotel in Washington, D. C., August 21-26, 1960.

The preliminary prospectus covering the international conference carries in detail information on registration, application to present a paper, scientific exhibit, scientific film, etc. A copy of this preliminary program may be had by writing to Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical Medicine, 30 N. Michigan Avenue, Chicago 2, Illinois.

## PG Course on Diseases of the Chest

The 13th Annual Postgraduate Course on Diseases of the Chest, sponsored by the American College of Chest Physicians, will be held at the Sheraton Hotel in Philadelphia, March 14-18.

The tuition fee for the five-day course is $75.00 for ACCP members, and $100.00 for non-members. The tuition will include the banquet on Monday evening, March 14, and the luncheons which will be held daily in connection with the meeting.

Further information may be obtained by writing Mr. Murray Kornfeld, Executive Director, ACCP, 112 East Chestnut Street, Chicago 11, Illinois.

## Ob. & Gyn. Examinations, Part II

The American Board of Obstetrics and Gynecology has announced that oral and clinical examinations (Part II) for all candidates will be conducted at the Edgewater Beach Hotel in Chicago, May 11-16. Formal notice of the exact time of each candidate's examination will be sent in advance of the examination dates.

Candidates who participated in the Part I examinations will be notified of their eligibility for the Part II examinations in the near future.

Further information may be obtained by writing to the secretary, Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

## Charleston Physician in Israel

A Charleston physician, Dr. Willard Pushkin, left recently for Israel where he will spend a year as a physician in a collective colony.

He and his wife will live in the colony of Haogan where he will engage in the practice of medicine among the people living in that community.

Doctor Pushkin, who is associate chief of staff at Charleston General Hospital, was stationed on the Persian Gulf in Palestine while serving a tour of duty with the Medical Corps of the U. S. Army during World War II.

## TB Association To Meet in Los Angeles

The Annual Meeting of the National Tuberculosis Association will be held in Los Angeles, May 16-18. The Statler Hilton and the Biltmore will be convention headquarters.

The American Trudeau Society, medical section of the Association, will also meet at that time and plans are being completed for the scientific program. In addition to the general scientific sessions, there will be five panel discussions and seven luncheon seminars.

## Cancer Society Headquarters Moved

State headquarters of the West Virginia Division of the American Cancer Society have been moved from Huntington to Charleston. The new offices are located at 1211 Quarrier Street, with the executive director, Mr. Ralph G. Beveridge in charge.

It has been announced that offices will be opened Monday through Friday from 8:30 A.M. to 4:30 P.M.

## State Physicians To Receive 1960 Roster of Members

The 1960 Roster of Members of the West Virginia State Medical Association will be mailed to members early in January. The Roster will include the names and addresses of all members of the State Medical Association, broken down by component societies.

It will also include a listing of the members of the standing and special committees, together with the officers of the various sections and affiliated societies and associations.

## Another Procrustes' Bed

The arguments against the Forand Bill are overwhelming: it does not cover all those who really need help; its cost is $1.1 to $2.3 billion to start, almost unlimited thereafter; free choice under H.R. 4700 is virtually no choice, either to participate or to choose your own health care vendor; voluntary efforts would be discouraged; it is a foot in the door to socialized medicine; quality of care will suffer from abuse, overuse and malingering; and federal support means federal control and regimentation.

I was impressed with the testimony of Frederick C. Swartz, M. D., Lansing, Michigan, Chairman of the AMA Committee on Aging, when he appeared before the House Ways and Means Committee on H.R. 4700:

"If we abandon the community approach in favor of a rigid national health program we will, in effect, have constructed another Procrustes bed. The mythological Procrustes, you will remember, developed a bed that was just the right size for everybody. There was only one trouble with it. Procrustes, instead of altering the bed to fit the person, altered the person to fit the bed. He accomplished this feat of legerdemain by trimming off the legs of the tall, and stretching his shorter victims on the rack."

Medicine, and its individual members, must speak out firmly, clearly, unequivocally—and now—that this legislation will result in poorer, not better, health care for the people of this country.—William H. Hildebrand, M. D., in Wisconsin Medical Journal.

## Mental Health Manpower

Figures, which defy perversion, note that of the 20 per cent of the country's youth who rank in the top fifth of high-school classes in intelligence less than 7 per cent graduate from college—certainly a waste of potential in view of the undeniable advantages of a higher education.

Applied to the requirements of mental health and its antonym, this waste is particularly disturbing in view of the expressed need for 20,000 psychiatrists whose work is now being attempted by only 10,000; a need that is compounded by the present yearly population growth of 3,000,000 potential patients.—New England Journal of Medicine.

# PROBLEMS OF THE AGED AND AGING

## Some of The Statements Presented Before a Public Hearing

**Conducted by the**

**U. S. Senate Subcommittee on Problems of the Aged and Aging**

**Presiding Officer:**

**Senator Jennings Randolph, West Virginia**

**State Senate Chamber—The Capitol**

**Charleston, W. Va.—Nov. 3, 1959**

**E. Lyle Gage, M. D., Bluefield. W. Va., Past President of the West Virginia State Medical Association, and Chairman of the Committee on Aging.**

Senator Randolph, Ladies and Gentlemen: I am E. Lyle Gage, M. D., Chairman of the West Virginia State Medical Association's Committee on Aging.

The members of the West Virginia State Medical Association have long been interested in the many problems of advancing age. We welcome the studies being made by your Committee and we hope we may be of help by submitting this report.

We doctors know our patients are persons who, as the years go by, have problems not unlike our own, yet we have learned to observe our patients objectively. In Plato's Republic, Cephalus said to Socrates: "For he who is of a calm and happy nature will hardly feel the pressure of age, but to him who is of an opposite disposition youth and age are equally a burden."

An unknown author has also expressed our observations well when he wrote,

"Age is a quality of mind;
If you've left your
Dreams behind,
If hope is cold,
If you no longer look ahead
If your ambitious fires
Are dead,
Then, you are old!"

It would seem to us that over the last twenty-five years the so-called problem of the aged has developed not only because of increased life span and the growth in population, but also because of a changed and possibly dangerous attitude of mind on the part of individuals and organizations. The philosophy of adventure and independent enterprise has tended to give way to domesticity, search for employment by others, or just following the crowd.

Sayings such as "Nothing ventured, nothing gained," "God helps him who helps himself," and "A stitch in time saves nine," are seldom heard. Perhaps we should teach our children more of such fundamentals in preparation for their old age.

We seem to have changed from a work-minded people to a security minded society, and, at times, it would seem that we have developed a national complex of mother fixation, where the Federal Government has come to represent the mother image in the minds of many people and they look to the Great White Father for all remedies for all things. This attitude is certainly unhealthy for a nation, as well as for an individual. Yet, we are born with the same fundamental needs, as Dr. Howard Rusk has pointed out in his three points in Rehabilitation. "A person needs a home, a job, and love to be successfully rehabilitated."

West Virginia has great geographic variability as well as historical and occupational differences in various parts of the state. Provisions for support as well as medical care in the later years is also different depending upon occupation, community, and family background. Yet, wherever inquiry has been made our people in their older years have hoped for security, independence, preservation of integrity, and maintenance of self care as long as possible. Many older people prefer to be treated medically at home and do not want to enter hospitals.

In thinking about the aged, it has seemed that we could divide them into a possible six groups for discussion: (1) Healthy active persons, who can care for themselves physically and financially. (2) Healthy active persons, who are out of work or indigent. (3) Ill, deformed or physically dependent persons with financial means. (4) Ill, deformed or physically dependent persons without financial means. (5) Unattached misfits and ne'er-do-wells who have come to old age with nothing. (6) The genteel aged, who are cared for, but would prefer to feel independent if it were possible. Naturally, these groups have subdi-

visions, but let us consider some of the needs of each as it applies to their medical care.

For group one, we perhaps may defer action at least for the present, for the members of that group do provide for and care for themselves; also some of the other groups need our consideration so much more.

Group II, who are healthy and active, but are out of work or indigent, should in some way be provided with an occupation at which they can earn a livelihood. The formation of industries and work shops for the elderly and the retention of people in their jobs at part time would be of great benefit. Most older persons do not want a hand-out or institutional care if they can get along in some other manner. If we could provide a means of continued occupation with commensurate remuneration, reasonable housing, and satisfying recreation, we could go a long way toward solving the problem of our aging population in West Virginia.

Actually in West Virginia, we need essentially the some things for both Groups III and IV, namely a larger number of proper nursing homes and hospitals for the chronically ill and infirm. We now have about 72 nursing homes of more than 5 five beds each. There are 500 to 600 homes of less than 5 beds, unlicensed. We need some additional personnel to staff these institutions, and then for Group IV we need a means of financial maintenance and support on a local level. Channeling of some of the present federal personal income tax funds for local use would do a great deal.

Group V and its members pose a problem in West Virginia, just as they do elsewhere and always have done to some degree. Certainly we have no such group of derelicts as we find on Skid Row in some large metropolitan areas, and our rural areas solve the problem by unorganized foster homes and care by relatives. Many of these aged are on DPA or OASI.

I am sure that many of us know older people who fit into Group VI, of the kindly, gentle aged, who are cared for by friends or relatives, but who would much prefer to feel and be independent in a properly run home, such as some of our communities are preparing for their aged. However, many of them would have preferred this all their lives, but never have achieved it.

Can our communities meet the problems of these groups? I believe they can with local leadership, adjustment of laws, some release from federal taxation, and with proper public attitude. However, West Virginia is somewhat different from some of the more urban states as shown by the following figures taken from a Guide For State Agencies On Aging, published by the United States Department of Health, Education, and Welfare:

In 1950, 65.4 per cent of the population of West Virginia was rural. In 1949, men over 65 averaged $863.00 per year income, but 22.5 per cent had no income. Women over 65 averaged $387.00 per year income, but 58.9 per cent had no income. In 1957, the average per capita income in West Virginia was $1,554 per year. In 1953, 549,900 workers in West Virginia were reportedly covered by OASI, 17,200 were 65 to 74 years old, and 3,000 were over 75 years old. In 1958, the total active applications for employment of the unemployment offices in West Virginia were recorded as 66,346. Of these, only 475 or 0.7 per cent were over 65 years old. This would indicate that a very low percentage of people over 65 years had applied for employment, and certainly the lack of diversity in situations available for employment of older people in West Virginia probably had something to do with this figure. DPA, pensions, local help from community funds, local charities, and self-sustaining savings, plus Social Security, are known to help most old people to carry on in our state, but certainly there are some who cannot have these benefits available to them and must continue to work or survive as best they can. In my own area they are cared for medically when necessary.

West Virginia has some shortage of licensed nursing homes for the care of the aged as related to our needs. Hospital beds for the chronically ill and infirm are short in number in West Virginia as elsewhere, but there has been an awakening to the need and there are some plans toward meeting it. West Virginia has about 1,800 doctors of medicine, 1,550 of whom are active in practice. Every area of our state is served by medical service.

The State Medical Association has taken positive action in our state toward a program for the care of the aged. On December 11, 1958 the Committee on Aging of the West Virginia State Medical Association held a meeting in Charleston, and the following recommendations were made: "That component societies be urged to set up local committees on aging; that Governor Cecil H. Underwood be asked to arrange for a statewide conference on aging at such time as he may think propitious, and that the State Medical Association assist the Governor in every way possible, suggesting groups which might well be represented at such a conference; that a speaker's bureau be set up so the speakers might be available to discuss problems of aging at meetings over the state; that arrangements be made at the proper time for a survey of the aged in West Virginia; and that there be an investigation of insurance law, Compensation statutes, and DPA regulations."

It was also recommended "that the AMA be asked to request the Census Bureau to provide in the forms to be used in the taking of the 1960 census questions that will supply answers to many of the problems now being considered by the various committees on aging; and that the committees on Insurance and Blue Cross-Blue Shield be requested to study available programs for medical treatment and hospital care to ascertain what particular plans or commercial insurance companies are providing coverage for persons 65 years of age and over."

The recommendations were implemented by the Council of the West Virginia State Medical Association. The Governor was consulted and stated that he would call a statewide conference at the proper time. This conference was held in Charleston, September 25, 1959, and was well attended. It was the first statewide conference in our country in preparation for the White House Conference in 1961.

County committees were set up in county medical societies. The Blue Cross-Blue Shield Committee

recommended that definite action be taken toward improving the care of the aged, and that the physicians in the state accept 50 per cent of the usual charge to Blue Shield for patients over 65 years of age with an income of $3,000 per year or less. This has been accepted.

Representatives of the West Virginia State Medical Association have attended meetings in Chicago, Washington, Atlantic City, and Ann Arbor. The Chairman of our Committee on Aging spoke at the Conference on Aging in Clarksburg, July 11, 1959. Many physicians are becoming interested in Geriatrics and a return to home calls is noted among younger general practitioners. The publication "Geriatrics" is being read by more of our membership.

Physicians are and always have been charitable to those who are aged or infirm without means. I know of no other provider of the necessities of life and health who by tradition has given, and therefore seems to be expected to give his services and substance regularly on demand whether the user thereof can or cannot pay. We expect to do this, for ours is an honorable calling and we are proud of our heritage and our place in society.

The West Virginia State Medical Association's Legislative Committee aided in the enactment of a law in 1958 which established a licensing board for practical nurses and permitted the training of these nurses in West Virginia. Several classes of practical nurses have been graduated and many have passed the licensing examinations.

At least four scientific articles pertaining to the medical care of aging persons have been published in *The West Virginia Medical Journal* in 1959, and another article is in process of approval. Editorials have called attention to the needs and opportunities in Geriatrics.

Ambulance service to our rural population has been improved with the addition of small compact ambulance cars by several of the companies, and this has been encouraged. Further improvement of our secondary roads would help. Many of our rural areas are rapidly acquiring electrification and telephones. These help the physician in both his maintenance of contact with older people as well as with their medical care. With a little thought, new dwellings can be built to include both the new look, so pleasing to the young, and the new functional practicality which will be so useful when the occupants are older, or if they become handicapped.

The Rural Health Committee of the West Virginia State Medical Association has held annual conferences with farm organizations at Jackson's Mill, and this year has embarked upon a new survey of rural health needs in our state.

It is hoped that the findings of this survey will help us better to meet those needs of both old and young among people in the country. Several doctors in rural and mining areas have acquired jeeps and other small cars which help them reach out-of-the-way patients.

I am sure that, with the national publicity which is being carried on concerning the White House Conference, attention will be so focused on the care of the aging that there will be a revival of that wonderful pioneering spirit of neighborliness where those who have will help those who have not. Such a revival should be encouraged.

In Ann Arbor, it was stated that one of the purposes of the White House Conference would be to recommend legislation to the Congress in connection with the care of the aging. It seems to me that the delegates from West Virginia to the conference, as well as the report from this hearing, might advocate some laws, revisions, or considerations as follows:

(1) Revision of retirement laws, regulations, and practices, so that chronological age will no longer be a criterion for enforced retirement.

(2) Revision of compensation laws to enable the employer to provide work for older people without placing his business in jeopardy if an employee suffers a stroke or a coronary occlusion on the job.

(3) Revision of old or the formation of new tax laws to provide exemption for specified funds placed by a worker in reserve for retirement, medical care, sickness insurance, and purchase of housing for himself and family.

(4) Release of some local and personal taxes by the federal government if the money is used wisely, carefully, and in an efficient manner to care for the aged at a local level.

(5) Utilization and coordination of state schools and training centers for special classes in the care of the aged.

(6) I hope that we may ask that there shall be no extension of national bureaucracy with its customary appropriations and added taxation established in Washington in the name of Care for The Aged.

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**Charles A. Hoffman, M. D., Huntington, W. Va., Past President of the West Virginia State Medical Association, and Chairman of the Insurance Committee.**

Mr. Chairman, I am Dr. Carl Hoffman, and I am engaged in the private practice of medicine in the city of Huntington, West Virginia. I specialize in the field of urology. As a representative of the West Virginia State Medical Association, I have been requested to discuss the medical care which is available to our Senior Citizens, through both voluntary and involuntary health plans. Although my statements will be directed largely to our situation in West Virginia, I believe I should also discuss briefly our national picture. With your permission I shall make a few personal observations.

When one looks at the records nationally, approximately 9 million of our 15½ million Senior Citizens over 65 years of age are covered by some form of insurance. It might appear that these statistics are not too encouraging, but if one points out that this progress is the result of but a few short years in the endeavor to provide medical care, then the result is most gratifying. We can foresee that within a few years we may expect almost complete medical care coverage for this group.

The Health Insurance Association of America has predicted that by 1970, 90 per cent of our Senior Citizens desirous of health insurance will have that protection. Blue Shield and Blue Cross, which have traditionally retained the aged members within their plans, have created increasing interest among our

commercial insurance carriers and stimulated a few of them to offer the same benefits.

Today 26 of our 72 Blue Shield plans representing approximately one-third of our total Blue Shield membership offer non-group enrollment coverage to those over the age of 65. Although the Blues have always allowed a continuation of a member's coverage to any age if acquired before age 65, the idea of non-group coverage of our Senior Citizen is new. In fact, only four plans offered this coverage over a year ago. These figures exemplify the rapid progress in our efforts to give adequate medical care to the older age group.

It is worth noting that all of the remaining Blue Shield plans except 12, which comprise only 8 per cent of the membership, are developing special programs for the aged; therefore, it can be said that 92 per cent of our Blue Shield enrollment is in those areas where special plans for the care of the aged have been completed or are in the process of development. In this connection it is interesting to note that our Senior Citizens of West Virginia have virtually the same medical coverage as those of the nation.

West Virginia has 6 Blue Cross Plans and 8 Blue Shield Plans, which give voluntary medical protection to approximately 325,000 of our citizens.

Credit must be given to the "Blues" for initiating voluntary health insurance and the continuation of a member's coverage after retirement age. However, commercial insurance companies have also developed extensive health and accident coverage within our state, and a few have offered continuing coverage to group members after retirement without change in their status. Commercial companies have also been extremely active in offering non-group health coverage to our older citizens.

Efforts to provide medical care to the citizens of our rural communities have been emphasized. The "Blues" in this state are working closely with the Farm Bureau so that a sizeable number of those living in our farming communities are enrolled in that form of voluntary coverage. I feel sure that you are aware that a large segment of our rural population is covered medically by other organizations such as the United Mine Workers Welfare and Retirement Fund. In addition, many individuals who work and have health coverage in our cities live and do part-time work on our farms. It has been estimated that 20 per cent of our population are beneficiaries of the United Mine Workers Welfare and Retirement Fund and 11 per cent of our population receive aid from the Department of Public Assistance, Aid to Dependents, and Aid to the Blind.

The Blue Cross and Blue Shield plans in Wheeling, West Virginia, which cover the counties of Ohio, Wetzel, Marshall and Tyler, exemplify the rapid growth of voluntary health coverage within the state, 34 per cent of all their members being on a non-group basis. Of this 34 per cent, 40 per cent are in the rural communities. It is also worth noting that 17 per cent of both group and non-group coverage with those individuals are 65 years of age or older.

It would appear that due to this statewide effort for health coverage of our Senior Citizens, we shall within a few years have the great majority of our older-age group protected.

The physicians of West Virginia are of the opinion that at present our greatest need is a broadening of the medical program of our Department of Public Assistance. These beneficiaries are taken care of by both hospitals and physicians to the best of their ability, even when D.P.A. funds have been depleted. Such depletion of funds could cause a limitation of hospital service to worthy patients. Every effort should be made by the federal government and our state officials to study our D.P.A. medical program and if possible expand these services.

It appears to the physicians of the state that every effort should be made to increase our nursing home facilities and nursing home care, particularly for the indigent and the lower income group. It is true that some progress in this field has been made, but more effort is needed. A careful survey of this problem should be instituted with recommendations for improvement.

As a practicing urologist, it is my privilege to work largely with the older group, and since I have practiced not only in a city but also in rural communities, I should like to make some personal observations. To my knowledge, I cannot recall any patient in the older age group who has been in need of medical care to whom medical care has been denied. It is obvious to the lay person that a small minority of any age group will consider themselves neglected regardless of any medical treatment given. I find that the majority of my senior patients have some form of voluntary medical care coverage. Those who do not have coverage have never been a problem. I, as well as most of my colleagues, charge a patient what he can afford to pay, and unless there is evidence of deceit, he may set his own fee.

Accredited hospitals must set aside a certain number of beds for charity cases. These usually run from 6 to 10 per cent of their bed capacity. Each physician in order to maintain his staff privileges must devote a portion of his time to the care of these patients. In fact, it has been my experience that these charity cases receive the very best of care, for the resident staff often takes great pride with this group, since their care is under the close scrutiny of the other members of the staff.

We, the physicians of West Virginia, have for some time recognized the need of more adequate medical care for our Senior Citizens. We are encouraged over the progress that has been made regarding this problem; however, the medical profession realizes that we must accelerate our efforts in providing health care for our aging group. I am satisfied that the medical care of the Senior Citizens of our state will show the same rapid development that we see in our nation.

Gentlemen, I can assure you that the physicians of this state and country will do their best to provide voluntary health care to their Senior Citizens now and in the future.

**Mrs. G. Thomas Evans, Fairmont, W. Va., Past President of the Woman's Auxiliary to the West Virginia State Medical Association, and a member of the West Virginia Commission on Problems of the Aging.**

Senator Randolph, Ladies and Gentlemen: I am Sarah A. (Mrs. G. T.) Evans, a member of the West Virginia Commission on Problems of the Aging.

As the older citizen of our communities has been subjected to close scrutiny and careful study, certain factors pertaining to medical care on a voluntary basis have begun to emerge. It has been recognized that coverage must probably be extended beyond mere emergency hospitalization. But in all categories involved, the medical profession through its affiliation with Blue Cross-Blue Shield plans and more than 1000 voluntary insurance companies, is attempting to solve the many problems inherent in this type of insurance for the older segment of our population. Completely the opposite from a stereotyped coverage provided by a universal compulsory system, these plans afford the individual a wide choice in the amount and extent of coverage. During the 65 years, the following are some of the methods that have been developed for use in insuring the aged:

1. Continuation of insurance on older active workers under group insurance plans.
2. Continuation of group insurance on workers who retire and their dependents.
3. Continuation on an individual policy basis of coverage originally provided by group insurance, this being accomplished by conversion of the group coverage on termination of employment or membership in the insured group.
4. New issuance of group insurance on such groups of older people as associations of retired persons or employees, retired teachers and civil servants and Golden Age Clubs.
5. Continuation into later years of individual insurance purchased at the younger ages.
6. New issuance of individual insurance at advanced ages. Many of these forms do not require evidence of insurability and after a nominal waiting period cover loss due to preexisting conditions.
7. Issuance of insurance that becomes paid up at age 65, thus enabling the policyholders to pay for his protection during his productive years.[1]

Through these and other methods notably those of the service plan type insurers the percentage of the aged population having some voluntary health insurance has grown at a remarkable rate. According to the Health Insurance Institute of America, 60 per cent of our senior citizens who need and want health insurance will have protection by the end of next year. And, the Institute says, that percentage will increase until three-quarters will be covered in 1965 and 90 per cent in 1970.[2]

What happens if you arrive at age 65 and have no coverage? This can easily happen when you consider that many group policies automatically cut off their members from any kind of coverage after retirement. The problem is compounded by the fact that people over 65 are most likely to need medical care. This means that coverage must be either quite skimpy or else quite expensive. And in most cases the applicants for this kind of insurance must show that they are in good health.

Here are some examples of so-called senior hospitalization and surgical policies available to older people in West Virginia: American Casualty Company of Reading, Pennsylvania, offers a Senior Hospital Expense Policy for persons over age 60 who are in good health. It pays various amounts per day for hospital room and board, depending upon the benefits selected, which vary with premium size.

For example, the policy would pay up to $10 a day for 90 days on any one disability, plus up to $100 miscellaneous hospital expense, plus up to $200 surgical expense at an annual cost of $86.66 for either men or women. The policy is not guaranteed renewable, and applicants must fill out a questionnaire about their health.

New York Life writes a policy for people aged 60 to 75 that is guaranteed renewable for life. Applicants, of course, must fill out a medical questionnaire. At the $10 a day hospital rate with up to $100 miscellaneous hospital expense and up to $250 surgical expense, the annual cost would be as follows:

| | Age 61-65 | Age 66-70 | Age 71-75 |
|---|---|---|---|
| Men | $ 82 | $ 91 | $101 |
| Women | $ 99 | $107 | $117 |

As noted above, most hospitalization and surgical policies require the filling out of an application. If answers indicate a physical condition the company thinks is uninsurable, the company may refuse to issue the policy. If the answers indicate questionable conditions, the company may request the applicant to submit to a physical examination. In some cases an applicant who has had certain serious diseases or physical impairments but who has recovered can obtain insurance at a somewhat higher rate. Such policies are called substandard or qualified-risk policies. Often they require a waiting period during which a particular specified condition is not covered.

Continental Casualty Company of Chicago has pioneered in this kind of policy, as well as policies designed for older people. In 1957, for example, Continental offered in Iowa an experimental hospitalization and surgical policy for older people called "65 Plus." This program was reopened in Iowa last fall and extended to Illinois, Indiana and Wisconsin. This policy is not now available anywhere, but the company expects to extend it further in a few weeks, based on the experience in these states to date. During enrollment campaigns, any person 65 or over can buy coverage and there is only one limitation in the matter of the applicant's health. This is a provision that for the first six months of coverage no benefits will be paid for any disability resulting from conditions that previously have been treated or known. Benefits are up to $10 per day for hospital room and board for a maximum of 31 days; up to $100 miscellaneous hospital expense; and up to $200 surgical expense. Premium is $6.50 per month.

At present, Continental is offering a group policy for people over 65 that requires neither medical examination nor questionnaire and contains this limitation on

pre-existing conditions. During the first year of coverage, no payment will be made for any condition for which the insured was hospitalized during the preceding twelve months. This group policy is available to all members of the American Association of Retired Persons, 310 E. Grand Ave., Ojai, California. Membership in this association is open to anyone age 65 or over.

The policy does not pay too much in benefits—up to $10 a day for 31 days for each hospital confinement, up to $200 surgical benefits and 50 per cent of miscellaneous hospital expenses up to a maximum of $125 (50% of $250). Nevertheless, this is probably the first time that a hospital and surgical plan of any kind has been available to people over 65 without wide limitation on pre-existing conditions. Membership in the American Association of Retired Persons is $2 a year. For this, the member receives a subscription to a bimonthly magazine and may buy the group insurance on himself (or herself) for $6 a month. For another $6 a month the insurance may be extended to cover husband or wife.[3]

Recognizing certain pitfalls and shortcomings in the protection provided by voluntary health coverage plans, some recommendations stand out clearly:

1. Continued intensified study by voluntary insurers and Blue Cross-Blue Shield plans to amplify existing programs in all directions for the benefit of the insured.
2. Extension of the right to continue coverage by individuals when they leave employment or when they retire.
3. General incorporation into existing policies of the right to convert upon leaving a group by retirement, without medical examination or any evidence of insurability, into a guaranteed renewable lifetime major medical expense policy covering himself and those of his dependents who were covered under the group plan.
4. Development of a public education program to stimulate awareness and understanding of those reaching age 60 or 65 of their rights and responsibilities with reference to their present insurance policy so that coverage will not lapse or be forfeited.
5. Emphasize the importance of providing noncancellable insurance while insurable.

### References


1. Proceedings, Joint Council to Improve the Health Care of the Aged.
2. The Medical Profession's Program on Aging—A Community Responsibility.
3. Changing Times—The Kiplinger Magazine (January 1959).


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**C. Royal Kessel, M. D., Ripley, W. Va., member of the West Virginia Commission on the Problems of the Aging.**

Senator Randolph, Mr. Harrison, Ladies and Gentlemen: I am C. Royal Kessel, M. D., a member of the West Virginia Commission on Problems of the Aging.

Pursuant to conversation held with Chairman J. Floyd Harrison and the other members of the Commission, I have continued my efforts to enlist the cooperation of the medical profession of West Virginia as well as the facilities of the Medical Center at Morgantown.

I am happy to report that the medical profession has wholeheartedly endorsed the movement of which we are a part, and even devoted a part of the program at the Annual Meeting this summer at White Sulphur Springs to this important problem. The officers are now asking that they have a prominent part in our arrangements for the 1961 White House Conference in Washington. This is a very healthful condition and I recommend that we keep the physicians fully informed of our plans as they develop from time to time, and that a group of physicians be invited to go to Washington with us.

I went to Morgantown the past week to ascertain what efforts are being made to activate the scientific studies necessary to provide us with the accurate information that we will need from time to time so as to propose intelligently what additional steps are to be taken.

I am happy to report that in the enormous undertaking at the Medical Center, much wisdom has been displayed by those responsible, and that a program is being devised whereby all of the facilities and activities of the University and most of the agencies of the State of West Virginia are being correlated and integrated in such a way that not only the State of West Virginia but the whole United States and the world will profit enormously.

The curriculum is slowly taking form. The committee which is now working on it consists of two physicians, Dr. Clark K. Sleeth and Dr. J. B. Harley, and the other three members are Drs. C. C. Boyer, A. D. Kenny and F. J. Lotspeich, doctors of philosophy, who have been made members of the committee for the purpose of correlating allied sciences. Dr. E. J. Van Liere, the present Dean, is of course a member of the committee *ex-officio*.

The officers of the University, the Board of Governors, and the curriculum committee above named, are progressing cautiously in selecting proper personnel to conduct this gigantic undertaking at the Medical Center. For example, in one position alone, they have examined nine well qualified men but have not reached a decision, feeling that the matter should be given further study.

The chair of medicine is expected to be filled by commencement time next summer. The committee feels that since the professor of medicine must carry out the program, he should have much to say about the course of study and how it should be organized and carried out; therefore, they have not advanced too far in the preparation of the curriculum.

I believe that I can safely report that there will be a large department of geriatrics with lecture and hospital facilities, laboratories and library material, all of which are to be combined with social and allied sciences that will not only provide care for the aged, but advance our knowledge of the needs our aged persons require.

It is quite within the realm of possibility that our state, which in the past has been somewhat backward

in its contributions to medical science, may soon be among the leaders in this respect, and we might not be too egotistical to think that we might take the lead.

You will be interested to know, I am sure, that it is the plan of those who master-mind this enormous plant of ours not to consider it finished with the completion and furnishing and staffing of the Medical Center. The construction of many additional units is contemplated, one of which will be a hospital for the aged to be constructed as a unit in itself. This, however, will possibly not become a realization for a decade, or more.

It might not be inappropriate for us to write a letter to the Chair of Medicine at the Medical Center, expressing our appreciation of the proposed facilities for the care of the aged, and respectfully requesting permission to talk with the Head of the Department shortly after he is named concerning the proposed curriculum as it pertains to geriatrics.

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**Charles E. Staats, M. D., Charleston, W. Va., Immediate Past Chairman of the Rural Health Committee of the West Virginia State Medical Association.**

Senator Randolph, Members of the Committee Staff, and Guests: I am Charles Staats, surgeon of the licensed and fully accredited private hospital which bears my family name. I am a member of the local, state and American Medical Association, and a Fellow of the American College of Surgeons.

During the last 23 years, with the exception of the war years, I have practiced medicine at the same location and have worked considerably with elderly people. For seven of the last eight years, as Chairman of the Rural Health Committee of the West Virginia State Medical Association, I have participated in the yearly state-wide Rural Health Conference, and two such conferences have concerned aging and the retirement years.

Staats Hospital is a general hospital designed for acute illnesses, and might be termed a family hospital. In some instances, fourth and fifth generations have received services at this hospital. Many of these patients are from rural homes.

I am acquainted with the aging and its sequellae.

A summary of elderly patients in this hospital for this past year has been completed, and relevant data is summarized in the accompanying chart.

During the survey year the medical staff of 30, hospitalized 296 patients over the age of 65 who presented most of the problems accentuated by aging. Although only 8.3 per cent of West Virginia's population is said to be over 65, these 296 represent 11.2 per cent of the total number of patients admitted. Among these elderly patients 39 were surgical, of which two died; 241 were medical, of which 14 died, and 16 were orthopedic, with no deaths.

This represents one year's experience of this hospital, and no attempt should be made to explain other hospitals' experience, elaborated from our findings. This is not a report of what might happen; rather it is what did happen.

If unpaid hospital bills are a measure of financial insecurity of the aging group, our experience does not reflect the commonly held concept. 1.5 per cent of our bills of the over 64 age group at this time are unpaid. In the over 85 group 0.3 per cent of the bills remain unpaid. In this over 86 group this amounts to $15 unpaid. In contrast, other patients under 65 had 14.9 per cent of the hospital bills remaining unpaid. Our financial experience with elderly patients has been very satisfactory.

As expected, increased age increased both the length and the cost of hospital services. The average for patients:

| | |
|---|---|
| under 65 | 5.5 days at average cost of $126.41 |
| over 65 | 10.1 days at average cost of $254.12 |
| from 65 to 74 | 10.1 days at average cost of $260.73 |
| from 75 to 84 | 9.4 days at average cost of $227.96 |
| from 85 and over | 14.1 days at average cost of $324.76 |

The longest stay was one of our nurses' aides who died of cancer after 163 days, and a bill of $4,109.75. This bill was paid by insurance, that is prepayment, and private means.

From an economic point of view, patients can be divided into three groups:

First, there are the people who are solvent and remain solvent, and need no help at any age. My personal observation agrees with that of my father, that people who remain at productive work into advanced years present little or no problem.

Secondly, those called "medically indigent" who remain solvent under ordinary circumstances but be-

**SUMMARY — STAATS HOSPITAL, CHARLESTON, WEST VIRGINIA**
**JULY 1958 — JUNE 1959**

| *Class by Age* | *Number of Patients* | *Per cent* | *Average Stay* | *Average Charge** | *Total Charges* | *Amount Unpaid* | *Per cent Unpaid* |
|---|---|---|---|---|---|---|---|
| All Patients | 2,633 | | 6.0 days | 140.77 | 370,642.78 | 45,218.42 | 12.2 % |
| Under 65 | 2,337 | 88.8 | 5.5 days | 126 41 | 295,423.18 | 44,113.87 | 14.9 % |
| Over 65 | 296 | 11.2 | 10.1 days | 254.12 | 75,219.60 | 1,104.55 | 1.5 % |
| 65 - 74 | 192 | 7.3 | 10.1 days | 260.73 | 50,060.03 | 479.64 | .96% |
| 75 - 84 | 89 | 3.3 | 9.4 days | 227.96 | 20,288.14 | 609.91 | 3.0 % |
| 85 - up | 15 | 0.6 | 14.1 days | 324.76 | 4,871.43 | 15.00 | .3 % |

*Average charge calculated for each admission.

come overwhelmed and lose their productivity by financial reverses; these need only temporary help.

And third, the indigent who have seldom or never worked, and whether they be 15 or 85, present major problems in the triad of food, shelter and medical care.

It is exceptional to find patients shifting from one group to another, and it might seem that the greatest help would be to boost in some manner the indigent into a self-sustaining group.

Interestingly enough, private means paid higher and higher percentages of bills as the age increased. At the ages of 85 and older 90.6 per cent of the charges were paid by private means. Prepayment plans paid 6.1 per cent. Under the age of 65, on the other hand, 33.9 per cent of the charges were paid by private means, and 63.6 per cent was paid by prepayment plans.

In both groups the remainder of 3.3 per cent and 2.5 per cent were paid by agencies of private, community or governmental nature.

Again, in the over 65 age group, seven of the accounts were over $1,000, of which two were paid by insurance; all the others were paid by private means. Only 31 accounts, including the above, were over $500. Twenty-six charges were under $50. The lowest charge was $8.50. Four patients were over 90, women of 93, 99, and 99 surviving; all paid. Thus it seems that there may be little basis for the common thought that costs of hospitalization are unbearable to the aged.

This review of a year's admissions of the aged surprised most of us at the hospital, but when I asked the admission clerk, the accountants, and the cashier they were not surprised. They said it was much more difficult to collect accounts of the younger aged group at 25 to 45 than of elderly patients, but they said that when an older patients had no way of paying he would be truly "rock bottom." But it is obvious that such "rock bottom" patients do receive medical care, for some bills remain unpaid.

Thus it seems that there may be little truth to the commonly-held thought that older people provide most of the health problems in the community. It becomes obvious that a legal age of need, at 55, 65, 75, or 85, is false. It also appears that to destroy an existing program of coordination between many agencies, organizations, and individuals, and to bring in a substitute, might bring increased problems.

In conclusion, I want to state that in my opinion hospitals and doctors, with the help of insurance companies and agencies of governmental, community, and private nature, are striving with considerable success to meet health requirements in their communities, according to the need.

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**Mr. Lyle Austin, Hogsett, W. Va., Vice President of the West Virginia Farm Bureau.**

We appreciate the opportunity to present the views of Farm Bureau regarding the needs of the rural aged in West Virginia.

We have been especially conscious of the problems in the field of rural health. Our County and State Farm Bureaus have been active for several years in support of prepaid hospital and medical service plans and has used special personnel to promote and encourage the use of these plans.

Farm Bureau has played an active role in West Virginia in helping to extend voluntary hospital and medical service plans to the rural and farm people. In cooperation with the Blue Cross and Blue Shield Associations some 8,000 West Virginia farm people are now covered on a voluntary basis through membership in Farm Bureau.

Farm Bureau is opposed to any proposals to provide a compulsory health insurance program and our opposition is of many years' standing. We do not believe that any detailed proof is necessary to show that a compulsory government program of health insurance would very seriously impair, if not completely supersede, and inhibit the development of voluntary programs.

We believe that any successful effort to amend the so-called Social Security Act to provide for payment of benefits to retired and survivor beneficiaries under this Act will be followed by more steps to expand the coverage to include other and larger groups of our citizens and ultimately lead to socialized medicine. Anyone who is thinking along this line should study the present day picture of conditions under the socialization of medicine in England.

The original intent of the Old Age and Survivors Insurance Act was to provide a retirement income to those who had earned it. (We submit that this is also a compulsory type of program.) Now the objective of the social planners seems to be to substitute the Old Age and Survivors Insurance program for the program of public assistance to the ill and needy. We submit that this kind of thinking and expression is building up false hopes to the unfortunate and needy and is encouraging the spread of the false philosophy of "getting something for nothing."

The West Virginia Farm Bureau, speaking for its 4,225 member Farm Families, sincerely believes that we can care for our aged and needy rural people without further Federal legislation or interference.

Farm Bureau further is opposed to any increase in Social Security Taxes for this or any other purposes. Any increase in this tax is and will be promptly reflected in the cost of living index. Further increases in costs and prices simply adds to inflation—the cruelest tax of all. The Social Security Tax is already a heavy burden on the self-employed and should not be increased. Under present law the tax rate will be almost double during the next decade.

We in Farm Bureau are very conscious of the medical needs of our older people. We also know that medical bills can be burdensome. However, the farm people of West Virginia are able and willing to pay their way and only ask to be allowed to continue to use individual income in a society based on freedom of choice.

We have the best medical care of any people in the world. To launch out on a program of limited socialized medical care would greatly hinder the efforts being made by volunteer groups, such as Farm Bureau, in promoting better medical care for all of our citizens.

**J. Harold Laughlin, Charleston, W. Va., President of the West Virginia Hospital Association.**

Mr. Chairman, my name is J. Harold Laughlin. I am president of the West Virginia Hospital Association and I am the administrator of Staats Hospital in this city. I appreciate the opportunity to appear before this sub-committee and wish to express my thanks on behalf of myself and the Board of Trustees of the Association.

For your information briefly, the West Virginia Hospital Association represents 97.5 per cent of all non-federal and non-State owned hospital beds in West Virginia.

### Introduction

Many of the assertions we will make in this statement are based on long experience in the hospital field and some cannot be documented immediately as well as we would like. This is because first, we did not have time between notice of our participation in this hearing to today to collect the data we usually try to have to back up our statements all the way; and, secondly, because many of the problems of the aged and aging are just now identifiable. I am sure the committee has found this to be true based on its experience in hearings in other parts of the country. However, we are more than reasonably certain that our observations will be vindicated when proper surveys are made.

### Assumptions

We know that the needs of our aging citizens reach further than the need for hospital and health care. We are assuming that others here today have exhausted the field concerning housing needs, food, clothing, recreation and the like. With the understanding that we may duplicate in some places what others have said, we will confine ourselves to the hospital needs and services relating directly to hospital needs.

### Committee Charge

Your staff has asked specifically that we give our views on the following points: (1) The extent of facilities now available in West Virginia for providing hospital care for the aged and aging; (2) Our views as to how the situation might be improved; (3) Our views as to the problem of financing hospital care for the aged and aging; and (4) Any solutions we might have to offer along these lines.

### Definitions

You should understand from the outset that when we speak of a general hospital we mean an institution which is geared towards intensive care of acutely ill patients; provides x-rays, laboratory, anesthesia, surgery, drugs, and all the other services for patients in critical condition. The average stay in such an institution is normally seven to nine days. Such an institution provides highly trained professional personnel who work under the direct supervision of a physician or surgeon.

A nursing home, as we see it, is a custodial institution where it is possible to care for patients for a long-term, but the patients are sufficiently well enough not to need highly skilled professional care, and may require only routine supervision from a physician or a surgeon. This is generally true of convalescent facilities and chronic disease facilities, although the requirements for an ideal situation in each of the latter may vary to some degree.

### Facilities

At the present time, West Virginia has enough general hospital beds to take care of the acute illness problems of our aging citizens. There are some unsatisfactory aspects of this which will be covered later in our discussion of the financing of the care. We have 72 general hospitals in this state and while they are perhaps not ideally distributed, they are available in just about every area where there is a need. We do not see this problem of the aged and aging in panic proportions. But we can see very clearly that in the very near future, some steps are going to have to be taken to provide an organized approach to the hospital care of our aging citizens. Part of what I have to say in explanation of this point will easily apply to all age groups, but it will apply more especially to the aged as I will illustrate.

In the definition above of a general hospital, I tried to point out that it is geared to quick, intensive treatment. The average individual responds to this treatment rather quickly and it is possible to discharge him in a relatively short time. The aging patient does not respond quickly, for obvious reasons. In addition, an aging patient may have a multiplicity of diseases no one of which requires intensive care, but all requiring some care that he cannot provide for himself.

Our aging population is growing. The percentage of aging going into the general hospital is, naturally, growing along with the general growth of the population. In addition, the miracle of modern medicine is making it possible for people to live much longer with diseases once described as incurable. In some of these cases, the period of intensive treatment is still just the average seven to nine days, but the aging patient cannot be released from the general hospital because there is no facility to give him the less intense care which would be acceptable to the medical profession. This is not at all meant as a reflection on our existing nursing homes and should not be interpreted as such. But it is a statement to the effect that more nursing or convalescent homes are going to have to be provided to give us a place to discharge our patients to when they no longer need the intensive care we give them, but do need some general medical supervision. This type of supplementary facility serves best when it is a part of or closely integrated with a general hospital.

If a system of nursing home-hospital relationship is not developed, then we will find many aging patients filling hospital beds that they do not really need, simply because there is no acceptable place to send them. This results in wasted general hospital facilities and wasted money.

There is also another stage in this care which can be applied to the aging, but not peculiar to them. I refer to further development of diagnostic out-patient facilities both in hospitals and in communities without hospitals. This is a step towards further realization of preventive medicine. We have a few such centers outside hospitals in this state where patients can go for check-

ups after discharge and keep in constant touch with their health situation without being admitted to a hospital bed.

Our hospital centers in the larger metropolitan areas are well equipped with diagnostic facilities on an out-patient basis. However, we do feel that there is a need for such facilities in many areas of our state and in some fashion construction and use of these facilities should be encouraged.

In summary, we will state that there is a need for an integrated system of general hospital-nursing or convalescent home and out-patient care to forestall any trend toward overutilization of general hospital beds by the aging group when such utilization is unnecessary.

These are conclusions which do not apply peculiarly to West Virginia. I am sure you have found statements similar to these in your prior hearings. We make them here merely to underline the need.

One other point we feel is worthy of mention before we leave facilities. We believe that facilities for the care of the aging should be as close to the home of the individual as possible. Taking him far away from home doesn't help the therapeutic process. This may be difficult from the point of view of efficiency.

### Financing

Financing care for the aging and aged has been, traditionally, a community effort. At the present time, funds for the payment of hospital care for the aged are derived either from one or a combination of the following:

(1) Public Assistance Funds
(2) Private Insurance
(3) Blue Cross-Blue Shield coverage
(4) The individual
(5) Private philanthropy

These are not listed necessarily in the order of availability or of importance.

Public Assistance payments to hospitals in this state are not what could be described as "woeful," but they are inadequate. Hospitals in this State receive far less than out-of-pocket expense for caring for beneficiaries of public assistance. At the present time, the State Department of Public Assistance will pay hospitals 90 per cent of their out-of-pocket expense in caring for these patients provided the 90 per cent does not run over $18 a day and provided the patient does not stay in the hospital over thirty days. Both propositions are difficult to substantiate, particularly when our average daily out-of-pocket expense last year was $23.09. We estimate *conservatively* that the loss by West Virginia hospitals in this category is around $250,000 annually. This particular problem could be solved only by Legislative appropriation.

We cannot supply figures which will substantiate our estimates on the other categories of availability of funds. We know that many of our aging citizens have Blue Cross-Blue Shield coverage which they carried over from their last employment. Blue Cross has pioneered in giving coverage to the aging. Private insurance is now experimenting in this area, but it is much too early to tell what this experience will be.

When the individual pays his own bill, we are never sure whether he was really financially able to do it or not. The aging have demonstrated more maturity and more responsibility in caring for their debts. Some of course do have the resources, but we know that many of them pay their bills with borrowed money. There is nothing wrong with this approach, but in this age group we know that one serious illness could wipe out the resources of many of them forever, thus providing payment for one bill, but not for the future. This is part of the problem of the so-named "medically indigent" found in all age groups, where the individual can provide the resources for food, clothing and shelter, but cannot provide for an illness.

Private philanthropy is listed with a "tongue-in-cheek" attitude since there is very little of it these days for the care of indigent cases. However, money appears to be plentiful from this source for construction of facilities.

Public assistance funds other than those officially provided by the State Department of Public Assistance are practically non-existent in West Virginia for as we can determine, only one county, Kanawha, has provided an independent fund for the care of indigent persons in any age group.

All this adds up to one very important conclusion. You have to understand that someone somewhere has to pay for the hospitalization of every patient, regardless of whether an individual has the money to pay for it or not. For every dollar lost by a hospital through caring for a patient of any age group, the fellow who pays his hospital bill in full has to be taxed to bridge the gap. This amounts to a community responsibility. We know we cannot continue very much longer taxing the pay-patient to pay for losses on other patients. It is an unfair approach and we know it.

### Solutions

*Facilities.* We think that federal planning agencies, the State Health Department in West Virginia and hospital people in this State are very much aware of the need for integrating the facilities mentioned earlier in this statement so that adequate convalescent, out-patient and general hospital beds are located in the right places to carry out the needs of the aging. The Hill-Burton hospital construction program recognizes this need and money is now available. Communities must be educated to the need and every effort must be made to keep federal and local money available for this type of integration.

*Financing.* There is no easy answer to the question of financing. The very first step, in our estimation, is to raise the level of payments of welfare agencies to meet at least the cost of out-of-pocket expenses of hospitals. This principle is endorsed nationally and it is also endorsed by our own State Department of Public Assistance. This will relieve part of the financial load hospitals and, ultimately, other patients have to carry in order to give proper hospital care to our aging patients. We think it is of paramount importance to give voluntary health insurance all the support possible to see if they can develop some answers to financing the care for our aging other than the indigent aging. Here we will repeat a statement made earlier that Blue

Cross came up with the answers to a pressing problem of financing in the thirties and there is a good possibility that they can come up with an answer again.

Our concluding statement is one we cannot emphasize too heavily: *the entire problem needs much more study than it has now received.* Organizations such as the Joint Council to Improve the Health Care of the Aged are now deeply involved in studying this problem with the sponsorship of the American Dental Association, the American Hospital Association, the American Medical Association and the American Nursing Home Association. We are committed to and believe in the voluntary principle of community action and before we can depart from that principle we will have to be soundly convinced that it will not work.

**Cooperation**

The West Virginia Hospital Association believes that the Senate of the United States has shown wisdom in making a thorough study of this very real need facing our aged patients. We stand ready to cooperate with you in any way possible in assisting you to bring your work to a constructive conclusion.

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# The West Virginia Medical Journal

February 1960 Vol. 56, No. 2

## Radiation Hazards in Diagnostic Roentgenology*

*Harold S. Pettit, M. D.*

The present uneasiness about the dangers of radiation is not new. Less than a decade after the discovery of x-ray, there were reports in the British press on radiation — induced cancer and dermatitis. Radiologists have long been aware that radiation is hazardous. Many of the pioneers learned from personal experience. Almost all of them became afflicted with epidermoid carcinoma of the hands, and it was not only painful and disabling but, occasionally, fatal. Leukemia developed in an impressively high percentage of the early radiologists. This is one of the reasons why the incidence of leukemia in radiologists has been reported to be higher than that among other physicians.

The current furor came into being with the bombing of Hiroshima, but it did not get into high gear until fall-out from the atomic explosions in the West aroused controversy about this danger.

There is no doubt that large doses of gamma or x-radiation are dangerous. But it has not been proven that very small doses are detrimental, either somatically or genetically.

X-rays are a form of radiant energy. When this energy is absorbed by a cell, whether it's a germ cell or a general body cell, certain alterations are apt to occur, depending upon the quantity of energy transferred. These changes are chemical and physical, and range from minimal and imperceptible damage to immediate death of the cell. Our principal concern in diagnostic roentgenology is injury to the chromosomes, that is, the breaking of a chromosome or mutation of a gene.

A dose sufficient to cause immediate cell death is never used in diagnostic work. There are two forms of injury to consider: somatic to the individual and genetic to future generations. The latter type is receiving the more attention because it is the more controversial, there being actually little concrete information upon which to base conclusions. In the meantime, we theorize, with different conclusions being reached by different essayists.

In the past, geneticists have held that there is no threshold below which some change does not occur in an irradiated cell. They started with doses high enough to produce definite effects, and as they increased the dosage they found that there was a linear increase in the observed mutations. Exterpolating in the other direction from these data, they have held that any amount of irradiation will be harmful to some degree. This has not been proven.

Another contention is that the dose is cumulative; that is to say, a roentgen today and a roentgen next month produce as much genetic damage as two roentgens today. It seems only logical, however, that, as in other reactions, there is a boiling point below which there is some electron activity but no disruption of the gene, or permanent chemical alteration from which the cell cannot completely recover.

There are two broad types of radiation which we are considering today. The first is background radiation, which is always with us. It consists of cosmic radiation and the radioactivity

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*Presented before the third general scientific session of the 92nd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 22, 1959.

Submitted to the Publication Committee, August 22, 1959.

of materials in brick, mortar and stone. Through natural selection mankind has adjusted to the mutation rate for which this excitation has been held responsible. Until recently, at least, when surgeons, pediatricians and others began meddling, undesirable genes were being eliminated at the same rate that they were being formed.

Now deformities are being corrected, the defective persons are carried into the child-bearing period, and the unwanted genes preserved. There is nothing practical we can do about this background radiation which varies from locality to locality, but which averages 4.3 r per person from birth to age 30.

**Table 1**

**RADIATION DOSAGE**

**Birth to Age 30**

| | |
|---|---|
| *Average Background* | 4.3 r |
| MAN MADE | |
| Present Average per Individual | 5.0 r |
| Recommended Limit—Average | 10.0 r |
| Recommended Limit—Individual | 50.0 r |
| Recommended limit between 30-40 years | 50.0 r |

From National Academy of Sciences, National Research, Summary Reports, 1956.

The second type of effective radiation is called "man-made." It includes medical x-ray, industrial x-ray, and all artificial radioisotopes. At present, medical x-ray is approximately equal to that of background radiation. We should always be conscious of possible danger and be alert to limit exposure to the gonads from birth through the child-bearing period. We must not, however, magnify the perils of radiation and become completely unrealistic. We have an obligation to the patient as well as to his descendants.

There has been too much excitement about the effects of radiation and a tendency to ignore the everyday factors which may be even more significant. Although this is called the atomic age it is also a chemical age. For example, our ignorance of the effect of drugs on mutations is abysmal. There is a steady stream of new insecticides which are extensively used. Almost everyone discussing this subject mentions the radium dial wrist watch. I am a conformist. The estimated dose to the male gonads from the radium dial is equal to seven x-rays of the pelvis.[1] This presupposes that the watch is continuously on the wrist with its face being kept 12 cm. from the testes, conditions rarely fulfilled. The wearing of trousers increases the temperature of the testes, and the additional heat has been estimated to have a genetic mutation effect equal to 1,200 examinations of the pelvis with the scrotum protected, or 5,000 series of upper G. I. films.[1] I am surprised that we cannot recognize a geneticist by his kilts.

**Hazards to Future Generations**

The geneticist feels that each group of people possesses a common pool of genes. An undesirable gene in one person may eventually be widely spread through the descendants of the group. He is afraid of mutations, feeling that the overwhelming chance is that any mutation will be an undesirable one. A mutated gene is likely to be a recessive gene, and probably will not manifest itself in the first generation. But when two defective genes are paired, disaster may range from a minor defect to a condition incompatible with life. The more mutations there are, the more deformities will be apparent. To mutate a gene knowingly and unnecessarily would be man's inhumanity to future man. Just how much irradiation in what period of time will cause how many mutations is the basic factor in our problem. In 1956, the National Research Council of the National Academy of Sciences[2] reported that in the 100,000,000 births expected in the present population there will be an estimated 2,000,000 infants with tangible genetic defects. They believe that if every individual in each succeeding generation were to receive a gonadal dose of 30 to 80 r, eventually there would be 4,000,000 deformities due to radiation-induced mutations per 100,000,000 births or double the prevalent rate provided the population level were to remain constant.

**Table 2**

**DOSE IN ROENTGENS PER EXAMINATION**

| *Part* | *Films* | *Skin Dose* | Gonad Dose *Female* | Gonad Dose *Male* | *Scrotum Protected* |
|---|---|---|---|---|---|
| Pelvis | AP | 0.65 | 0.115 | 0.43 | 0.03 |
| Lumbar Spine | 3 | 8.0 | 0.44 | 0.06 | |
| I.V.P. | 4 | 2.4 | 0.5 | 0.05 | |
| B.E. | 2 | 1.8 | 0.44 | 0.07 | |
| Upper G. I. | 4 | 3.6 | 0.24 | 0.016 | |
| Hip | 2 | 3.0 | 0.525 | 2.53 | 0.06 |
| Chest | 2 | 0.12 | 0.0008 | 0.00016 | |
| Mini Chest | Poor | 1.0 | 0.2 | 0.04 | |
| Mini Chest | Good | 0.12 | 0.00075 | 0.00025 | |

70 Kv, 2 mm Al. added filter

From Webster, E. W., Radiology 72 page 496, April 1959.

These geneticists have recommended, first, that the dose be kept as low as possible. Specifically, they suggest that man-made radiation be so restricted that members of the general population not receive an average of more than 10 r to the gonads between birth and age 30, and that no individual receive more than 50 r to the reproductive cells before 30 years of age, and no more than 50 additional r between 30 and 40. These recommendations were based on the assumption that mutations were directly proportionate to the

number of roentgens received before conception occurred. This was inferred from experiments with the spermatozoa of Drosophilia. Russell, Russell and Kelley[3] have since demonstrated that there is a difference in the mutation rate in spermatozoa and spermatagonia, and the latter one is the state in which the human cell will be during most of its irradiation. They proved the environment of a cell affected its sensitivity, also that the rate of the irradiation was a definite factor. In their experiments on mice, they definitely demonstrated that chronic gamma irradiation was decidedly less mutagenic than the same amount of x-radiation given in a short time. Much more work needs to be done but it appears that future revisions will be to permit more radiation rather than less.

### Hazards to the Individual

Of more immediate importance are hazards to the individual. Future generations cannot take us into court today.

In considering these hazards, let us start with the patient. The possible ill effects are skin damage, tumor formation, the causation of leukemia, shortening of life, and injury to the fetus during pregnancy.

In the early days of roentgenology, massive doses of x-ray had to be delivered to the skin before a sufficient amount had penetrated the body to make an acceptable x-ray plate. Late radiation dermatitis occurred and occasionally an epidermoid carcinoma developed. With modern equipment, there is no excuse for skin damage in diagnostic roentgenology. If a poor quality fluoroscope is used by a fluoroscopist to match, and the examiner becomes bemused by some finding, it is conceivable that skin damage will result. These conditions should not exist, but it is amazing how many interns and residents, just prior to starting practice, will ask for economic information about various fluoroscopes and how few will request instruction in their use.

A few years ago I listened to a paper on the shortening of the life span by radiation. I have forgotten many of the conclusions, but one was that life was shortened 15 days for every roentgen absorbed. That is absurd. Six hundred (600) r total body irradiation in one dose will shorten the life span to right now in half of the persons exposed, but there is no good evidence that repeated small doses have any deleterious effect. A recent study using mice found those exposed to irradiation living longer than the non-irradiated controls. A widely quoted work by Warren[4] found the life expectancy of radiologists to be 60 years as compared to 65 for physicians in general. You must remember that his material included the pioneers who were exposed repeatedly to high doses of x-ray over a long period of time.

Other studies, based on the lives of the latter day radiologists, have shown no difference in their life expectancies from that of their medical colleagues. So, shortening of the life span is not a hazard with which we need concern ourselves at present.

Malignant changes in tissues following heavy doses of radiation have been reported. An increased incidence of carcinoma of the thyroid has been noted in children who earlier had had therapy for enlargement of the thymus. Osteogenic sarcomas have developed in bones underlying treatment sites. There was an increased incidence of leukemia in survivors of the atomic attacks in Japan, and studies of patients who had received large doses of x-ray to the spine in the treatment of rheumatoid spondylitis revealed more leukemia than was to be expected normally. In all of these cases the amount of x-ray involved was far greater than the dose delivered in even a long series of x-ray examinations. There is at present no evidence that small doses of radiation are carcinogenic. Insofar as the patient is concerned, we can ignore the possibility of inducing cancer. The habitual use of x-ray machines and fluoroscopes is a different matter. The operator may absorb thousands upon thousands of roentgens over the years if he does not observe standard rules of safety. I was recently consulted by a general practitioner who owned a fluoroscope from 1930 to 1932. Two years ago numerous epidermoid carcinomas of both hands had begun to develop.

Examinations during pregnancy pose a special problem. Intra-uterine damage to a fetus is not a genetic effect. The deformity is due to injury of the cells as the various organs are being formed. The period of gestation on the day of the examination decides the type of the deformity. The system being organized at the time of the exposure is the one that is the most susceptible. According to studies by Rugh,[5] the most sensitive period probably occurs between the 18th and 39th days, for it is during this stage that the organ primordia are laid down by the rapid differentiation from primitive cell types. In this phase no x-ray examination should be done unless it is imperative and then all possible means for protecting the fetus are to be utilized.

Most research on fetal damage has been done with doses of 100 r to 200 r, but a few men have demonstrated that 25 r can produce certain slight defects. None of the data that have been ac-

cumulated so far has shown any damage to the fetus with less than 25 r.[6]

### Fluoroscopy Hazards

The ubiquitous fluoroscope in careless hands can be a dangerous instrument. Years ago, a surgeon I knew advised a colleague to buy a B.M.R. machine. He said, "It's wonderful. Mine paid for itself in no time." From the number of fluoroscopes in use, I suspect that this attitude has been transferred from the B. M. R. machine to the fluoroscope. The B. M. R. apparatus had the advantage over the fluoroscope in that it was not dangerous except when the physician relied upon its results.

All owners of fluoroscopes should observe certain basic safety rules. The fluoroscopic tube must be well housed so that there will be little stray radiation in the room. The field being exposed must be reduced to the part that is actually being examined at the time. The tyro has the impression that visibility increases with the size of the area of the screen illuminated because there is more total light. Actually the reverse is true. As the size of the port is enlarged details fade and lesions disappear due to the scatter radiation and loss of contrast. The busy internist or general practitioner is not likely to take the time that is required for good light adaption and, as a result, he uses far more fluoroscopy time than is really necessary, in addition to which he increases the risk of missing a visible lesion.

Everyone in a fluoroscopy room, except the patient, of course, should wear a lead protective apron, and the examiner should wear a good pair of lead gloves. The lead in gloves eventually cracks, and if one is not careful he may find that he is depending on a lead sieve for protection. Examine your gloves carefully, and when in doubt have them x-rayed. Even with the protection of a glove the hand should never be put into a direct beam of a fluoroscope until it has been attentuated by passage through the patient, and this should be limited. A good rule for an examiner is for him to ask himself, "Is this maneuver really necessary?" before he places his hand on the patient's side of the fluoroscopy screen.

Hand switches on fluoroscopes are a frightful and an unnecessary hazard. Several times I have turned off the lights in a fluoroscopy room and been unpleasantly surprised to see a brightly lighted screen, occasionally with the patient waiting in the full beam. Once the patient had been prepared for a barium enema and had been lying over the open tube for an estimated three minutes waiting for me to arrive. The hand switch was stuck in the "on" position. That was when all hand switches were removed from our fluoroscopy machines. Our technicians are repeatedly warned not to place a patient over a tube or in front of it without being sure that the tube is not energized. All fluoroscopes should be checked after installation and after any repair work to be certain that the dose to the patient's skin does not exceed 8 r per minute. The casing must be checked for leaks. The tube should be 18 inches from the skin of the patient and the beam filtered with at least 2 mm. of Al. For a given visibility there is less radiation using 90 Kv than 70 Kv. We use 90 Kv routinely, and our machines are fixed so that not more than 3 Ma can be obtained. Above all, fluoroscopy should be done for a purpose. The fluoroscopist should know what information he is after, look for it, and quit. Except for motion studies, films are more informative; they are a permanent, demonstrable form of evidence, and they require fewer roentgens. In cardiac catheterization image intensifiers are highly desirable.

### Radiography

In radiography, care should be taken to do the examination right the first time. The kilovoltage should be high, with 2 mm. Al added filter. The table taken from the data accumulated by Trout, Kelly and Cathey[7] shows the wide range of dosage to the skin in roentgenograms of the abdomen for various factors. There is no essential difference in the quality of films made with these factors, but the gain decreases sharply after 85 Kv have been reached. The beam should be confined to the area of the body to be examined. Proper cones will reduce the amount of radiation absorbed. The ideal cone cuts the corners of the film. Rectangular cones have been suggested further to reduce the amount of radiation, but the improvement is fractional, and the expense of replacing present cones considerable. Lead protectors for the testes have been devised, which are

**Table 3**

**RELATIONSHIP OF Kv AND FILTER TO DOSE**

| *Kv.* | *Filter* | *Skin Dose mr* | *Transmitted Dose mr* |
|---|---|---|---|
| 60 | 0.5 mm Al | 1,830 | 25 |
| | 3.0 mm Al | 464 | 25 |
| 85 | 0.5 mm Al | 860 | 26 |
| | 3.0 mm Al | 290 | 26 |
| 130 | 1 mm Al | 320 | 30 |
| | 3 mm Al | 180 | 29 |

From Trout, E. D., Kelley, J. P., and Cathey, G. A.: The Use of Filters to Control Radiation Exposure to the Patient in Diagnostic Roentgenology. American Journal of Roentgenology, Radium Therapy and Neuclear Medicine. 67:946-962, June 1952.

unnecessarily cumbersome and which require too much intimacy. When the technician is a shy, young female and the patient is an attractive, young male, the technician is going to be too embarrassed to use one of the elaborate commercial protectors. A simple plaque of lead, however, or a piece of leaded rubber with lead equivalent of 1.5 mm. can be laid across the patient's pubis and thighs for satisfactory protection.

A not uncommon situation in which large, unnecessary doses of x-ray are delivered to the gonads is disease of the hips in infancy or childhood. Children with Legg-Perthe's disease of the femur, or infants with congenital dysplasia of the hip, require numerous follow-up examinations. It is necessary to expose the entire pelvis on the first examination, but on subsequent visits the gonads can be shielded with ease and without loss of essential information. In other examinations such as intravenous pyelograms and spine films it is easy to shield the testes, but if the ovaries are covered we may obliterate the very evidence we are seeking.

### Films and Screens

Fast films and fast screens have been developed to reduce the skin and ovary dose to about one-third of that delivered with standard film screen combinations. There is a definite loss in film detail, however, that has dimmed enthusiasm for these materials. There is also a definite increase in expense that might at times be considered. At any rate, these materials have had limited acceptance so far.

### Summary

In summary, radiation is a destructive form of energy, but its dangers when it is properly applied have been exaggerated in recent years. Carelessly handled, it can injure the user or the patient, and I doubt that such injury to the patient in diagnostic work could be justified in court. Do not forget, however, that antibiotics, narcotics, hormones, and other drugs can be every bit as harmful to the patient if used improperly. In fact there are few materials used by physicians that would not be injurious if used carelessly.

Subtle and hidden genetic insults are of more concern, mainly due to the paucity of reliable information. At present, we have no good evidence to indicate that the small doses received in properly done diagnostic work have any effect. In spite of this, the possibility of mutations must be kept in mind in each examination undertaken, with the thought of reducing the dosage to the minimum. Use optimum technical factors, and use the fluoroscope sparingly before the end of the child-bearing period. This applies particularly to fluoroscopy in children.

When in doubt about the advisability of a roentgen examination, consult your radiologist.

The furor, and the rash of conflicting statements concerning it, reminds me of a passage from "A Tale of Two Cities":

> *"It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair."*

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*. . . the man who removes mountains begins by carrying away small stones.*

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# Some Technical Considerations in the Surgical Management of Varicose Veins By the Stripping Procedure

*Jules F. Langlet, M. D.*

PRIOR to the last two decades the only surgical procedure available to the patient with varicose veins of the legs was high and low saphenous vein ligation and subsequent multiple injections of the remaining diseased tributaries with sclerosing agents. With the advent of the stripping procedure, results of treatment of varicose veins changed from palliation to almost complete extirpation of the varices in one operation. This procedure offered to the patient a method of complete removal of the dilated and incompetent veins, thereby eliminating the multiple-injection technique, which was usually given over a long period of time. In addition, the operation offered improvement in the venous circulation of the leg, good cosmetic result, and less chance of recurrence.


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### Development of the Stripping Procedure

The stripping procedure for the removal of varicose veins began around the turn of the century with Dr. Charles H. Mayo, of Rochester, Minnesota. The vein stripper which Doctor Mayo devised was an extraluminal instrument. It was used to remove branches of the long and short saphenous veins, leaving the main trunk of the saphenous veins intact. The technique in this procedure consisted of making many small incisions along the course of the greater and lesser saphenous veins.

Keller, in 1905, introduced what today commonly is called "intraluminal vein stripping." His method consisted of using a wire which was threaded up the lumen of the varicose vein. The wire was twisted within the lumen of the vein until the vein collapsed and wrapped itself about the wire. The vein was then inverted and stripped out.

Within a few years other surgeons, notably Webb, Doyle, Mahorner, Babcock and, more recently, Myers, improved the intraluminal stripper.

Today the intraluminal vein strippers, as manufactured by the various surgical instrument houses, are basically similar. The end pieces on the vein strippers usually are cone-shaped, square, or flat discs, graduated in size and either detachable or permanently fastened to the shaft of the stripper. The major difference in the various strippers consists in the construction of the shaft. The shaft usually is of stainless steel and constructed in one of the following ways: a single, solid rigid wire; short rigid sections that are threaded for coupling together; twisted strands of cable wire; cable wire that either is woven, coiled or spiral. A shaft rod made of polyethylene has been recently introduced.

A notable disadvantage with solid shaft strippers is that they cannot readily be maneuvered through the tortuous veins. This can be overcome by using either the coiled or the spiral wire stripper, both of which have more flexibility. The coiled wire stripper, however, can readily become overstretched beyond the point at which it will spring back to its normal shape. The woven wire stripper has its disadvantage in that, when the vein is being stripped out, the operator may pull on the stripper at an acute angle, thus bending the wire shaft. A kink in the wire will result which will not always return to normal when the shaft is straightened out. Such a vein stripper will thereafter not function properly, especially in the manipulation of the stripper through tortuous veins. The kinked or sprung wire stripper will tend always to lead to one side and, therefore, treading the stripper up the vein channel becomes impossible.

Some surgeons who are adept at devising their own instruments have used the speedometer cable from old junked cars and have made firm, yet flexible strippers in various lengths.

### Selection of Patients for Surgery

Myers has set forth five indications for the stripping operation. They are (1) large varicosities, (2) stasis changes such as dermatitis, ul-

Submitted to the Publication Committee, July 24, 1959.

ceration, pigmentation and chronic induration, (3) a history or evidence of a single or recurrent acute attack of superficial phlebitis, (4) incompetence of both deep and superficial veins with venous stasis in which the superficial veins are a definite factor and (5) need for a prophylactic procedure.

Patients selected for the stripping procedure should have in general one or more of the above indications. Further diagnostic examination will aid in selecting those patients in whose cases the stripping procedure is feasible. This examination should in all cases include a complete physical examination and a careful examination of the legs. The leg examination should include the various tourniquet retrograde filling tests, test for patency of deep venous system, and inspection, with ballottement, for deep hidden veins within subcutaneous tissue.

Patients with ulcerations that are associated with surrounding cellulitis about the lower extremities should have, prior to surgery, treatment to clear up the infection and improve the ulcer. Such medical treatment should consist of bed rest, elevation of the affected leg, and control of the infection with hot compresses and possibly antibiotics.

A history of deep thrombophlebitis should extend at least one year before proceeding with the stripping procedure, and acute superficial thrombophlebitis should be treated conservatively, stripping procedure being performed after the phlebitis has subsided.

### Operative Technical Considerations

The patient should be well prepared. It becomes a nuisance and a handicap to confine the operative field because of unshaven areas and cumbersome excessive drapes. The patient should be shaved from the umbilicus to the toes.

The usual high and low incisions made at the groin and ankle usually will suffice to isolate the two ends of the greater saphenous vein prior to stripping. In order to remove the occasional large varicosities about the dorsum of the foot, an attempt occasionally is made to insert the stripper from an incision made at this level; however, too many times the stripper fails to proceed upwards and another incision has to be made at the medial malleolus. Time and effort can be saved if the incision at the medial malleolus is made first and the greater saphenous vein isolated. Then if large varicosities are present on the dorsum of the foot, the distal end of the saphenous vein trunk can be removed by retrograde stripping. In many cases no effort has to be made to remove these dorsal veins because once the distal end of the saphenous vein is ligated these varicosities are less marked.

In the leg that is extensively involved with varicosities, several incisions usually are needed to remove the communicating veins which obviously will not be removed by the vein stripper. Isolation and excision of these communicating veins can be facilitated if these varicosities, prior to surgery, have been localized by inspection and palpation and their position about the leg marked by scratch marks. Too many times large clusters or single dilated veins are missed because, when the patient is supine, the veins have emptied and then their presence is not obvious to the surgeon. Marking the veins with dyes is helpful; here again, however, the preparation of the legs with alcohol and ether, or with whatever skin preparation is used, will in many instances wash off the markings. An ideal method of marking varicosities is simply by scratching the legs with a sharp needle, with the patient standing, prior to being taken to the operating room. These scratch marks, no matter how lightly made, will become readily recognizable some 30 minutes later.

At times, large incompetent and tortuous varicosities are not readily seen. This will hold true in the case of the obese patient.

These varicosities located in the deeper subcutaneous tissues can be detected only by palpation or compression. The course and location of these deeper varicosities can be outlined by compression. With one hand compressing the vein in question, while tapping the vein elsewhere with the other hand, it is possible to determine the impact of the ballottement which, if transmitted over a distance of 20 cm., is considered an indication of incompetency.

These communicating veins should not be removed until the stripper has been passed into the main greater saphenous trunk. At times two or more strippers will have to be used. The entire greater saphenous vein will then have several strippers in place before its entire length has been completely channeled. If the communicating veins are removed before the main saphenous trunk is channeled with a stripper, the main trunk can become almost impossible to strip out since it becomes distorted and avulsed at various points.

The incisions used to remove the communicating veins will heal more readily if they are made in the direction of the normal skin lines. The cosmetic result also is greatly improved.

The removal of several clusters of varicosities that are closely associated yet separated by areas of normal appearing tissue can be accomplished by dissection through a long S-shaped incision

extending over the entire length of varicosities instead of through multiple small incisions. The resulting exposure is more ample, and a more thorough dissecting procedure can be performed. The long S-shaped incision heals as rapidly as the multiple small incisions and the operative scar is minimal, especially if the incision has been made in the direction of the skin lines.

The perforators and communicating veins about the calf and thigh usually can be readily dissected free; perforators that extend down along the sides of the tibial bone, however, should be dissected cautiously since these veins can be easily torn and hemostasis in this area is controlled at times only with great difficulty.

After stripping the main saphenous vein, the resulting flash bleeding can be controlled by applying manual pressure along the course of the excised vein. At times the varicosities about one leg may be so numerous that, with all the necessary incisions needed to do an adequate stripping, the patient probably will lose considerable blood, and if surgery on the other leg is attempted the total blood loss will be too great. This can be avoided if, during the stripping procedure on the first leg, blood is replaced as it is lost. Control of bleeding can be maintained further if the first leg is wrapped with an elastic bandage immediately after stripping. The elastic ace-bandage can be used as a temporary wrapper until the end of the procedure, when elastoplast can be permanently applied.

Figure 1. Large varicosities and incompetent greater saphenous veins about the knee and lower leg.

Figure. 2. Postoperative view of the leg some six weeks later. Note the long S-shaped incision which almost encircled the leg and was made to include varicosities from the greater and lesser saphenous veins.

The ideal situation when bilateral vein stripping is indicated is for two teams of surgeons to work simultaneously, each team working on a separate leg. The only hazard with the use of two surgical teams is contamination because of working in such close quarters.

The practice of using cloth elastic bandages to wrap the legs after stripping has been gradually abandoned. The main disadvantage of these bandages was that the edges rolled, with the result that the wrapper became uneven. The addition of adhesive tape around the leg to keep the elastic bandage in place did not tend to eliminate totally this annoyance but, rather, added another disadvantage, namely, the tourniquet effect caused by the encircling adhesive tape.

Elastoplast recently has been used and now appears to be the ideal bandage. It remains in

place, with little rolling of edges. To eliminate the tenderness caused by its removal from shaven legs, open 4 x 4 sponges or wide gauze strips can be placed over the entire surface of the leg prior to its application.

Application of the elastoplast can be more complete if, beginning at the ankle, it is wrapped clockwise on the right leg and then if, after the first roll is applied up to the knee, the second roll is applied counterclockwise. This enables a better turn of elastoplast about the upper leg to cover the incision at the femoral fossa. The same method can be used on the left leg; here, however, the first roll is applied counterclockwise and the second clockwise.

Following surgery, the patient should be up and about immediately after he has recovered from the anesthesia. During convalescence, the patient should prop the leg up on a stool when sitting and should never sit with legs dangling or crossed on one another at the knee, and he should be instructed carefully in this regard.

### Conclusion

The development of the surgical resection of varicose veins by the stripping procedure has passed through a phase of instrument creativeness. Now surgeons are beginning to refine their surgical technique of vein stripping and to improve on the total operative procedure as well as on the finer points of preoperative and postoperative care. Recorded here are some technical considerations which can be helpful in carrying out the stripping procedure successfully.

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# Solving Community Indigency Problems

MINISTERING to the poor has always been a favorite technic of politicians in winning elections. But ministering to the poor should be a matter of charity, not politics, and I use the word charity in its finest sense. I believe that the problems of individual indigency should be left essentially to our community chest agencies, to our families and to our churches. Government can help the indigent through these private agencies. It is in this field that the doctors and the other members of the health professions have been doing a magnificent job, but their light has been hidden under a bushel.

Fortunately, the problem of community indigency is being solved in the United States. There is still work to be done, but I believe our society is getting on top of this problem. The problems of indigency are by no means beyond the capabilities of the 98 per cent of the American people who are not individually indigent. But to succeed, that 98 per cent must keep from confusing the problems of the poor with other difficulties.

Much needs to be done in the field of health, but much is being done. The goose which produces the golden eggs must be nourished and cherished. The impatience and greed which the neo-federalists exhibit can produce only death for the goose and an end to the flow of golden eggs.—Congressman Thomas B. Curtis in Journal, Iowa State Medical Society.

# Accidents: Child Enemy Number One*

*Julian P. Price, M. D.*

Accidents are the leading cause of death in children in this country, and are responsible for one out of every three deaths among those between the ages of one and fifteen years. Accidents killed approximately 12,000 children last year, permanently crippled or disabled 40,000 to 50,000, and involved two million boys and girls to the extent of necessary medical attention.

To bring these facts closer home, here are figures for West Virginia furnished by the State Director of Health, Dr. N. H. Dyer: In 1957, there were 161 fatal accidents in children under the age of fifteen. (Contrast this with the total of nine deaths during the same period of time from five of the severe diseases of childhood, i.e., poliomyelitis, diphtheria, pertussis, measles and tuberculosis.) Add to these some five or six hundred who were crippled and fifteen to twenty thousand who required the care of a physician, and you get a broad picture of what accidents mean to the children—and the parents—of your state.

What can we, as practicing physicians, do to reduce this tragic toll? In attempting to answer this question, I do not pose as an expert. I am just a practicing pediatrician who has been keenly interested in the subject, and the suggestions I make have been culled from the writings of others and from personal experience.

The first task is that of learning how to handle efficiently the victim of an accident who comes to the office or hospital. If a child cuts his leg, the accepted procedure is to clean the wound, suture the laceration, and give tetanus toxoid or antitoxin. But when a child is extensively burned, the problem of what to do is not so simple. Should the burned area be cleansed? If so, with what agent? Should the child be given a general anesthetic? What type of dressing should be applied? Does the child need sedation, plasma, electrolyte solution, or blood? Upon the answer to these questions may depend the life of a child.

When a boy sustains a fracture of the clavicle, a well placed bandage usually will suffice. But what of the boy who receives a blow to the head with resulting loss of consciousness? Can he be cared for at home, or does he need observation in a hospital? What are the signs of impending trouble? When should surgery be considered? These are not easy questions, and the physician who attempts to handle such a case without knowledge and training is courting trouble.

When a child drinks kerosene (one of the more popular drinks among investigative youngsters today), an accepted method of treatment is to empty the stomach, give an antibiotic, and watch for signs of chemical irritation of the lungs. But what of the little girl who drinks furniture polish or eats some of her mother's reducing tablets? What are the toxic ingredients in these preparations? Is there an antidote? What are the complications that might develop? What is the prognosis? An immediate answer to these questions will help immeasurably.

### Aids to Reducing the Toll

To aid the physician in his handling of accident cases, I would suggest that more time be given in county and state medical meetings, in hospital staff conferences, and in postgraduate seminars to the discussion of such subjects as traumatic surgery, burns, shock, abdominal injuries, fractures and poisoning. I would also urge that every physician who deals with children and every hospital emergency room have available for quick reference a good textbook on traumatic surgery and a reference book which deals with household items which might be implicated in cases of accidental poisoning.

A recent development which has proved of great value is the establishment of poison centers in many of the large cities of this country. These can be called at any hour of day or night for information and help. Every physician should keep the telephone number of the nearest poison center within easy reach.

In addition to educating himself in the best method of treating accidents, the physician must


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*Presented before the third general scientific session of the 92nd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 22, 1959.

Submitted to the Publication Committee, August 22, 1959.

become more safety-minded in his everyday practice. A fertile field for such lies in the prescribing of drugs. Specific instructions should be given to the family and to the druggist. The mother should be told what the drug is for, and how it is to be given. General instructions on the label should be avoided. "A spoonful as needed" may be understood the day it is prescribed, but a month later the parents may have forgotten the indications for its use as well as the size of the spoon to be used, with regrettable results.

The amount of drug prescribed in the case of an acute illness should be limited to a quantity sufficient for two or three days only. Recently I saw a prescription for 6 ounces of a sulfonamide preparation for a child with a mild upper respiratory infection. I pictured what might happen. The child probably would be well by the time two or three ounces had been taken. The half-filled bottle would be put in the medicine chest or on the mother's bureau. There it would sit until it could be used for some subsequent illness in the family, or else it would be found by a venturesome youngster and gleefully drunk.

### The Skeleton in the Medicine Closet

I may or may not have been right in this particular instance, but I do know that the medicine closets of many families in this country are cluttered with bottles half-filled with medicine or boxes partially filled with tablets which are potential poisoners of children. To prescribe only what is needed for a specific illness and that for only a specific period of time is good medical practice; it is also one of the first steps in preventing drug poisoning.

### Education of Parents

Not only do we need to educate ourselves, we need also to educate the parents of our patients. We must take time to discuss accidents and poisoning in our offices, and this is of particular importance when the child is between the age of 9 months and 4 years—the danger age. Mention should be made of the type of activity in which the child is likely to engage, such as crawling, climbing, investigating with his fingers, pulling at any hanging cord, or putting objects in the mouth. The parent should be shown how these normal activities can lead to trouble.

Attention should be called to the special care which should be taken with regard to stoves, floor furnaces, hot water, stepladders and electrical outlets. The need for keeping preparations such as liniments, medicines, fingernail polish, floor wax and insecticides in a place where the child cannot get to them should be emphasized. A careful survey of the yard and playground should be made to see that hazards such as broken glass, wooden stakes and sharp tools are not present.

Literature should be available in the physician's office for parents to read and to take home. Instructive and well written pamphlets have been prepared by many of the major insurance companies and are available for use. Material on specific phases of safety education can be obtained from the National Safety Council. An excellent check list for parents has been prepared by the American Academy of Pediatrics. Published information of this type should be placed in the physician's waiting room. I have yet to see a parent who did not appreciate an article or pamphlet which dealt with safety when I presented it to him and asked that he take it and read it carefully.

Parents must be taught that many accidents can be avoided if the child learns certain simple yet fundamental safety habits. The parents must be convinced also that these habits should be learned at home. Children themselves should be talked to about accidents. Many a youngster will listen more attentively to his doctor than he will to his parents. Children should be told of the need for staying out of the street, of the care which they must exercise when riding tricycles and bicycles, of the danger of playing with fire and firecrackers. They should be warned against taking medicine of their own accord. Older children should be told of the need for caution with regard to swimming and diving, i.e., never to go swimming alone and never to dive headfirst into unknown water. They should be encouraged to take instruction in first aid and in life saving.

The physician should carry his educational campaign into the homes of his patients as he pays his calls. Here are some of the questions which he might ask himself as he goes to see the sick child: Are the stairs safe? Are there proper safeguards around the stove or floor furnace? Are cigarette lighters or matches lying within easy reach? Are the window screens securely fastened? Is there a safe place for medicines? From the answers to these and other questions he can judge the need for and offer pertinent advice.

### A Crusader for the Cause

Finally, the physician must carry his message to the public and become a crusader in the cause of accident prevention. He must convince others, as he has convinced himself, that accidents are in truth "child enemy number one." In the

office, in the home, on the street corner, at meetings of the P. T. A., before Kiwanis and Rotary Clubs, at public gatherings of all types—yes, even at medical meetings—whenever and wherever the opportunity presents itself, he must discuss the problem and enlist the support of others.

Smallpox was not eradicated with the discovery of smallpox vaccine; it disappeared only as the public was made to understand and was willing to be vaccinated. Just so, accidents will not be done away with through studies and research. They will be reduced only as those who are most concerned appreciate the problem and put into practice those measures which are effective.

In the vanguard of those who fight this great killer of our children must be the practicing physician. There will be little of the dramatic or sensational in what he does; it is the accident and not its prevention which makes the headlines. But many a child will live and enjoy life more fully if the physician is faithful to his task.

**Pamphlets on Accidents and Safety Which Are Available for Distribution in Physicians' Offices**

"When The Unexpected Happens"
"Safe At Home And In The Community"

John Hancock Mutual Life Insurance Co.
200 Berkeley Street, Boston 17, Mass.

"Your Family's Safety"
"A Formula For Child Safety"
"Caution! Babies Learning"

Metropolitan Life Insurance Co.
1 Madison Avenue, New York 10, N. Y.

"Your Child's Safety"

Nationwide Insurance
246 N. High Street, Columbus 16, Ohio

"Safety — Your Child's Heritage"
"Are You Sure Your Home Is Safe For Your Children?"

Prudential Insurance Company of America
763 Broad Street, Newark 2, N. J.

"Wet and Waterproof"

Equitable Life Assurance Society
393 Seventh Avenue, New York, N. Y.

# Management of Depression

The various chemical and electrical measures which have been advocated for the treatment of depression have waxed and waned in popularity as new ones have appeared on the market. In general, they have been only as effective as the skill of the physician who administers them.

It is of the utmost importance to realize that no physical procedure will, in itself, alter a patient's outlook on life or change his way of living. It is only through the way in which the patient interprets the procedure, or its effect on him, that any change can take place in this regard. This is why the confidence the physician expresses to the patient in the procedure he is employing has more to do with its effect on the patient than the procedure itself.

There is no chemical substitute for human interest and enthusiasm. The many drugs which are designed to stimulate or sedate people are, and will continue to be, widely used by physicians and if used with discretion can serve a useful purpose. In the long run, it will be found that the most significant action of the drugs will be their placebo effect.—Charles E. Goshen, M. D., in New York State Journal of Medicine.

# Available Blood, Fibrinogen, and Donor Systems In the State of West Virginia

*Theo H. Boysen, III, M. D.*

THE purpose of this article is to present the over-all state picture for an adequate and readily available supply of fibrinogen, blood and the donor system and to state a workable formula for arriving at the amount of fibrinogen to be stocked.

Dr. N. H. Dyer, State Director of Health, has just recently released a list by counties of the Hospitals, Clinics and Laboratories Having Daily Supplies on Hand of Fibrinogen, Fresh Whole Blood, and Those Operating a Donor System. These data are presented here in accompanying maps.

From these maps it is readily seen that ten counties have neither a hospital nor a clinic, while as of September 1, 1959, there are 12 counties with no hospital at all.

In the hospitals, clinics and laboratories of West Virginia, a daily supply of blood equal to 1242 pints is kept on hand and readily available

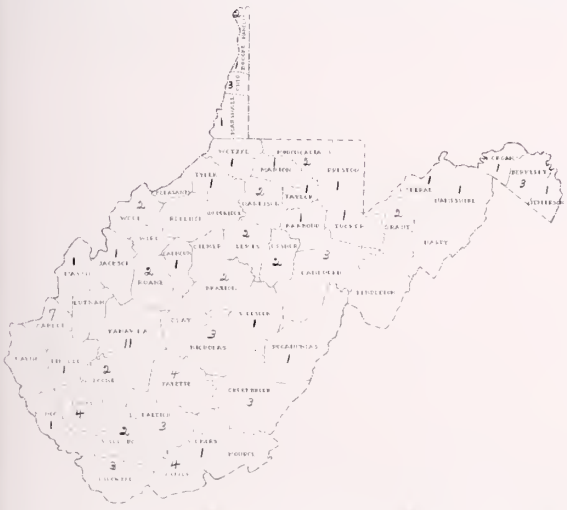

Figure 1. Number of hospitals and clinics in West Virginia (94).

in 29 counties, while 26 counties have none at all. Six of these counties, however, have available a donor system.

Twenty counties have fibrinogen on hand amounting to a total of 132 Gm. The areas deficient are clearly seen on the maps. The nearest point of supply for these areas in an emergency is readily ascertainable.

Submitted to the Publication Committee, September 24, 1959.


## *The Author*

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No point need be made for the indications and the usage of blood other than to mention the well used phrase, "BE PREPARED." Fibrinogen is indicated in those cases in which it has been

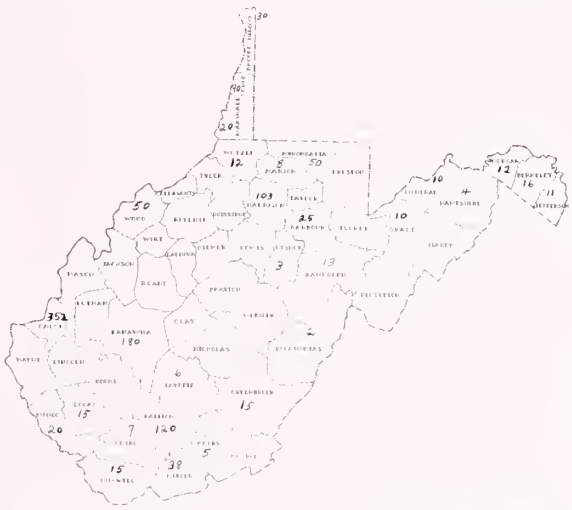

Figure 2. Available blood (daily average) in pints (1242).

Figure 3. Amount of fibrinogen in grams (132).

destroyed and is being destroyed as fast as it is produced by the liver. This is a mechanism of fibrinolysis as seen in toxemia of pregnancy and missed abortion. When the liver is damaged and cannot produce fibrinogen, the administration of the same can many times tide over the patient until the liver can regain some of its function. Acute yellow atrophy of the liver and liver necrosis as seen in toxic poisoning are examples of this. Uncontrolled oozing or bleeding not from a demonstrable bleeding point or points leads one to suspect the presence of hypofibrinogenemia. Simply taking 5 to 10 cc. of venous blood and placing it in the test tube in order to see if it will clot, is an easy, inexpensive and readily available diagnostic test to ascertain the presence of hypofibrinogenemia. When demonstrated, the intravenous administration of 3 Gm. of fibrinogen will control the bleeding within minutes. An additional one or two Gm. may be indicated. But for a start 3 Gm. are accepted by most observers as the empirical starting dose.

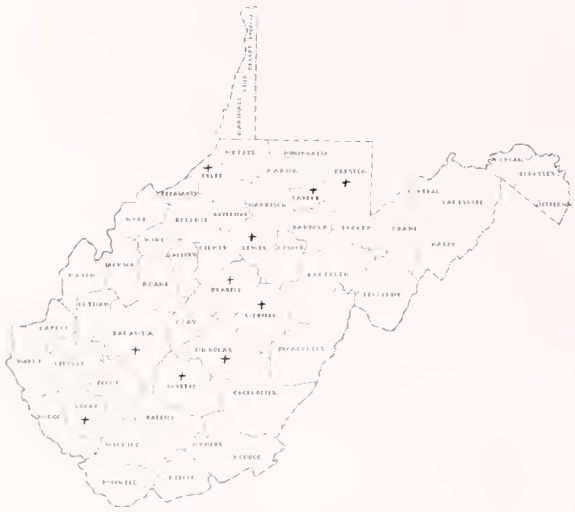

**Figure 4. Donor System (10).**

Dried fibrinogen is expensive. The cost commercially is approximately $36.00 per Gm. This is dated and has an expiration date. Therefore, it is advisable, because of the expense and the expiration date, to stockpile it wisely. For a hospital having 1000 to 1500 deliveries a year a supply of 3 to 4 Gm. of fibrinogen would be adequate. Since the opportunity for the use of this is not frequent and its use based on definite need as proven by the above outlined simple test, the above rule of 3 to 4 Gm. per 1000 to 1500 deliveries annually seems an acceptable base line for stockpiling. This will give us adequate protection and will eliminate the needless stockpiling of an expensive item which has an expiration date.

The survey of our available supplies of blood and fibrinogen and donor systems in the State of West Virginia is a timely one. It points out readily the areas in which we are deficient and the areas in which there is an oversupply of fibrinogen. This information is readily available for all hospitals in an emergency and is certainly worthwhile in the preparation of our disaster plans.

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# Osler's Advice Still Applies

To the student who is considering the study of Medicine, I have the following to say: Our profession is much older than any philosophy of political government in use today. It has outlived many and I am convinced it will outlive those concepts of government that would seek to destroy it by regimentation or control in one way or another.

If you come into Medicine, come ready to work hard, to sacrifice and to fight for the principles for which Medicine stands. Keep in mind the advice of Osler, "Start at once a bedside library and spend the last half hour of the day in communion with the saints of humanity." Remember always that Medicine is an art as well as a science. Learn all you can about both of these component factors from those with experience before you. Apply your knowledge with skill and with dignity and you will never regret your choice of profession.—Ralph W. Jack, M. D., in Journal, Florida Medical Association.

# Special Article

# Women in Medicine in West Virginia University*

*Edward J. Van Liere, M. D., Ph.D., and Gideon S. Dodds, Ph.D.*

The question of the place of women in the medical profession is still somewhat controversial. Since the authors have been connected with the School of Medicine of West Virginia University for many years, and know personally almost every woman who attended, we made this study of our medical school's alumnae. It is of historical interest that West Virginia University was founded in 1867, and that in its earlier years the admission of women to its classes was a matter of serious consideration, involving both the Board of Regents and the State Legislature. Although, during the early years, a few women were enrolled in some courses it was not until 1889 that co-education was generally established. The two-year medical curriculum was organized in 1902, and since the place of women in the student body was then generally recognized, the admissions officers of the Medical School admitted qualified women. The result has been that in about 70 per cent of the classes women have been enrolled.


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#### Sources of Information

Information regarding the women who began their medical training at West Virginia University was available from the files of the Medical School office, the records of the University registrar, the files of the alumni secretary, and in communications from the medical schools to which the women transferred for the completion of their training. Also, the American Medical Directory provided data on their professional careers.

To secure direct, personal information from the graduates themselves, the office of the School of Medicine sent out questionnaires in 1951 and again in 1957 to the 59 living women who had graduated from our school, who later received the M. D. degree from other institutions, and for whom we had available addresses. Forty-one women replied to one or both letters, usually recounting their personal stories and impressions of their role in medicine. Only a few questionnaires were returned for lack of proper addresses; however, we even did obtain some information on those women via newspaper clippings and other relatively indirect sources. Seven of the 59 are now deceased, and at least six of those died between 1951 and 1957.

We had to rely on the American Medical Directory for recent material on only eight of the 59 women. But even that source offered some difficulty in identification, because the professional names were not always the same as those in our student files, the changes being due mainly, of course, to marriage and remarriage.

By no means least, with regard to sources of information for this study, was our personal knowledge of these former students. Thanks to our small classes, we have been able to keep in touch with many of our students down through the years; we had, therefore, considerable first-hand knowledge concerning the professional careers of many of these women.

#### Number of Women Medical Students In West Virginia University

Up to and including the class entering in September, 1958, 89 young women (Table I) have commenced the study of medicine in West Virginia University. The number is 4.52 per cent of the total enrollment (1970) since the founding of the School of Medicine in 1902. In this connection, it is of interest that during the 1957-1958 school year 1,644 women were enrolled in medical schools in the United States. Their number was 5.57 per cent of the total enrollment.

Of our 89 women students, 81 were residents of West Virginia. They came from 45 different cities and towns ranging in size from our largest

*Certain portions of this article, including Table II, were published in the "Journal of Medical Education" (34: 911-915 (No. 9), Sept., 1959).

Submitted to the Publication Committee, October 18, 1959.

city to our smallest village. These communities are located in 30 of the 55 counties and lie in widely scattered areas of the state.

Of the remaining eight students not residents of West Virginia, seven were from three states and one from Puerto Rico. All eight were admitted in the earlier years before it became necessary to limit admissions to residents of the state.

Table I shows the number of women students admitted each year. It will be noted that of the 58 classes since 1902, 40 had female students. In the first ten years of the School's existence only one woman entered, but after that most classes contained from one to three females. Only two of the years show a significant departure from these figures when, in 1945, there were seven females and in 1946 five. This was due to post-war conditions which presented a shortage of well qualified male applicants. Fortunately, an unusually large number of outstanding women students were available so that the class could be brought up to full strength.

A perusal of the table will reveal the yearly trend in number of female students in relation to the total enrollment. The sharp decrease in total number of students in 1935 is due, as some of the readers may remember, to the correction at that time of an over-extended enrollment in favor of a sharply limited class chosen on a strictly merit basis. The number of female students at that time showed a decrease for a few years.

#### Their Success in the Study of Medicine

Of the 80 women who entered up to the year 1954 (the last class having time to complete its work), 64 earned the M. D. degree. This number is 80 per cent of those who entered, and it is almost the same percentage of success as that of the men during the same years. Table I shows, year by year, the number of women who completed the work for the M. D. degree.

One of the measures of attainment of these women lies in the fact that all had to transfer to some other medical school at the end of the sophomore year in order to complete the last two years of the curriculum. This is worthy of note, since transfer from one medical school to another may create a genuine hardship for some students. It is a pleasure to record that, without exception, the 64 women who were admitted to other medical schools with advanced standing from West Virginia University School of Medicine were successful in completing the work and qualifying for the M. D. degree.

Of the 64 M. D. degrees, 25 were from the Medical College of Virginia, with which school we have had an agreement since 1942 for the acceptance of a certain number of our students after the completion of the second year. The remainder were accepted by and received their degrees from the following: Rush Medical College, 7; University of Maryland, 6; University of Pennsylvania, 5; University of Cincinnati, 3; Northwestern University, 3; Ohio State University, 2; Western Reserve University, 2; Washington University, 2; one each from the following: University of Georgia, Indiana University, Harvard University, Illinois Medical College and Ohio School of Medicine (these two no longer exist), Temple University, Woman's Medical College, University of Tennessee, and University of Pittsburgh.

Of the 20 per cent who did not complete the work of the first two years, the reasons for lack of success are not greatly different from those of the men who failed. Heading the list was poor scholarship, due perhaps, in some instances, to poor preparation in college, unwillingness to apply themselves, or lack of interest in medicine. A few had to withdraw on account of physical illness or emotional instability. In several instances, they were married shortly after withdrawing from school, and it is quite possible that these withdrew in anticipation of that event. It should be emphasized, however, that most of those who did marry while in medical school, married medical students, received their degrees, and entered the practice of medicine.

#### Localities of Their Practice

Of the 64 women who earned the M. D. degree, 58 were from families residing in West Virginia at the time of their entrance to medical school. With respect to their locations in the practice of medicine the great majority have lived in other states since graduation. An important factor in determining the localities of their practice is the circumstance that all of our students have had to attend schools in other states for the completion of their work. The locality and acquaintances during the years of clinical training often play an important part in the selection of a place to practice. The geographic location of the internship or residency training also may be an important influence in this connection. Another factor is that the married woman physician nearly always locates in an area which is advantageous for her husband. Regardless of the reasons, the State has lost the professional services of many of these capable and earnest women. This is especially unfortunate since in the scale of physicians per 100,000 population, West Virginia ranks forty-third, or sixth from the bottom.

### Marriage and Children

By the time the M. D. is received, or even earlier, both men and women have reached the age when the urge for marriage and the establishment of a home has begun to manifest itself. Here the sex differential becomes a cogent factor in determining the amount and nature of the professional activities of the physicians of the two sexes. It is well recognized that most women who enter the medical profession are by no means devoid of the desire for husband, children and home. The married female physician may, of course, be forced for a time to stand aside from the responsibilities of medical practice because of pregnancy and the care of young children. These factors obviously place her at some disadvantage.

Of the 64 women with the M. D. degree, in so far as we can learn, 45 have married. A few of these were married before entering medical school, some while in school, and the remainder after receiving the M. D. degree. Twenty-three of the 45 women married men with the M. D. degree. Some of the remaining 22, however, have married men in closely allied professions.

It is known that 22 of these medical women are mothers, the children involved numbering 47. Doubtless this figure is not final. Furthermore, the 45 marriages and the 47 children do not represent a total and final score for the 64 women, because the recent graduates still are young. Table II shows the number of marriages and children for those who entered medical school in each decade.

In the replies to our questionnaires some of the mothers commented interestingly upon their ambitions for family life, and the relation of the bearing and care of children to their professional careers. Some continued their practice with little interruption during pregnancies and subsequent deliveries, while others suspended practice entirely for a few years while the children were small. One is the enthusiastic mother of five children. She reported continuous practice since graduation except for a "month vacation following the birth of each child."

### The Fields of Their Practice of Medicine

In listing the different fields of practice engaged in by the women, we are limited by lack of definite information about some of them. It is noteworthy that more seem to be engaged in general practice than in any single specialty. Eighteen stated that they are so engaged and 10 others gave no specialty, so 28 probably are in general practice. Of course, some of those who did indicate a specialty may well be doing some general practice also.

Among the preferred or exclusive fields, obstetrics and gynecology leads with 7. This is followed by anesthesiology, with 5; pediatrics, 5; one or two in each of the following: neuropsychiatry, industrial medicine, diseases of the chest, ophthalmology, radiology, internal medicine, teaching and research. One stated she was a chemist, but gave no further details. Of those limited to a specialty, 5 were listed in the American Medical Directory as having been certified by specialty boards. A few of the women were engaged in institutional work. It does not appear that many who married physicians are in practice with their husbands, although some of them stated that at times they have assisted their husbands in practice.

### Amount of Their Medical Practice

It has not been possible to determine exactly the amount of practice of the women, either regarding the number of years or the intensiveness. In most cases, however, a reasonably good approximation may be made. On 20 we have no information except that obtained from the American Medical Directory, and three others have graduated so recently that they are not listed in the latest issue (1958).

Table II gives a summary, by decades, of the number who entered, their activities, and other pertinent data. The table shows that 52 of the 64 graduates have been in rather active practice since graduation. Of those entering between 1900 and 1920, the years of activity range from 28 to 40 years. In more recent decades, of course, the years of activity become less until, for those entering from 1940 to 1949, the potential years since graduation range only from 4 to 14. Yet for these women sufficient time has elapsed to enable most of them to become rather well established and to do much useful work. Of those in the most recent group (those entering in 1950 and later) some obviously have not had time to become established in any type of practice.

Of the 12 whose practice has been far from continuous, 10 are listed in the current American Medical Directory as "not in practice." Some of these probably are in this category only temporarily, although a few were so listed in earlier issues also, some of them for as long as 20 years. With respect to those who have not been continuously active, it hardly can be said that their training is of no value, because the medical knowledge and point of view of these women is of use in the home and in the various community activities in which they participate. It

should be noted in this connection that of the men who graduate from medical schools, not all have continuous records of active practice. Comparative figures on this sex differential would be of interest, though probably not of great importance.

Of interest in this connection is the career of Phoebia Gean Moore who, in 1899, three years before the organization of the first two-year program in 1902, entered the University and took the few preclinical subjects offered, such as anatomy, physiology, hygiene, and a few others. Then she transferred to the Illinois College of Medicine (no longer extant) from which, in 1903, she received the M. D. degree. She then practiced medicine in her home town of Mannington almost until the time of her death, 50 years later.

The writers could add, from their own personal knowledge, the names of our former students who through the years have been giving substantial service in our State, in cities and smaller towns, and in rural practice, thus bringing honor to the school and credit to their sex. And of those who have become established in other states, we know that many are giving commendable and solidly useful service in their communities. Through these women the State and its small medical school are making their contributions to the general welfare of medical practice throughout the country.

In summary, it may be said that Table II shows that the amount of professional activity of the group has been considerable, certainly enough to justify amply the admission of these women to the study of medicine. It should be noted too that the professional work of these women has not prevented a large percentage of them from enjoying the benefits of marriage and children.

### The Feelings of These Women About the Place Of Women in the Practice of Medicine

The questionnaires sent to our women alumni included a question about their estimates of the place of women in the practice of medicine, as judged by their own observations and experience. Practically without exception they replied that, in their experience, the practice of medicine was a comfortable and rewarding field for women. They felt that the male physicians manifested no prejudice towards them, and that they were treated with personal and professional respect.

In the questionnaire they were asked whether or not they would recommend the study of medicine to a daughter or close female friend. The general opinion was that provided such a young woman had a sincere personal desire to study medicine, also that she seemed to have the necessary personal qualifications, opportunity should be provided for her to enter that field. They strongly emphasized, however, that the choice

**Table I**

**Summarized Statement**

**NUMBER OF FEMALE STUDENTS BY YEARS, AND NUMBER OF M. D. DEGREES**

| *School Years Beginning* | *Total Students* | *Female Students Entered* | *M.D.* |
|---|---|---|---|
| **Medical Courses** | | | |
| 1899 | ? | 1 | 1 |
| **College of Medicine** | | | |
| 1902 | 6 | 0 | — |
| 1903 | 30 | 0 | — |
| 1904 | 12 | 0 | — |
| 1905 | 14 | 0 | — |
| 1906 | 22 | 1 | 0 |
| 1907 | 19 | 0 | — |
| 1908 | 9 | 0 | — |
| 1909 | 23 | 0 | — |
| 1910 | 7 | 0 | — |
| **Department of Medicine** | | | |
| 1911 | 8 | 0 | |
| **Total for College and Department** | | | |
| 1902-1911 | 151 | 1 | |
| **School of Medicine** | | | |
| 1912 | 5 | 0 | — |
| 1913 | 16 | 3 | 3 |
| 1914 | 4 | 0 | — |
| 1915 | 8 | 0 | — |
| 1916 | 21 | 1 | 0 |
| 1917 | 15 | 2 | 2 |
| 1918 | 26 | 1 | 1 |
| 1919 | 31 | 2 | 1 |
| 1920 | 44 | 0 | — |
| 1921 | 53 | 1 | 1 |
| 1922 | 54 | 0 | — |
| 1923 | 53 | 2 | 2 |
| 1924 | 61 | 0 | — |
| 1925 | 60 | 2 | 1 |
| 1926 | 61 | 0 | — |
| 1927 | 55 | 2 | 2 |
| 1928 | 64 | 3 | 2 |
| 1929 | 65 | 1 | 1 |
| 1930 | 71 | 3 | 2 |
| 1931 | 74 | 3 | 3 |
| 1932 | 73 | 4 | 4 |
| 1933 | 79 | 2 | 2 |
| 1934 | 71 | 3 | 1 |
| 1935 | 24 | 1 | 0 |
| 1936 | 19 | 2 | 2 |
| 1937 | 26 | 2 | 2 |
| 1938 | 30 | 1 | 1 |
| 1939 | 25 | 0 | — |
| 1940 | 26 | 1 | 1 |
| 1941 | 30 | 3 | 1 |
| June 42 | 30 | 2 | 2 |
| Mar. 43 | 30 | 1 | 1 |
| Dec. 43 | 31 | 2 | 1 |
| 1944 | 30 | 2 | 2 |
| 1945 | 30 | 7 | 6 |
| 1946 | 30 | 5 | 3 |
| 1947 | 31 | 3 | 3 |
| 1948 | 31 | 2 | 1 |
| 1949 | 31 | 2 | 2 |
| 1950 | 31 | 3 | 3 |
| 1951 | 32 | 0 | — |
| 1952 | 32 | 1 | 1 |

should be made by the individual herself, and not on the recommendation or urging of any person or persons. It might be remarked that this freedom of choice should apply equally well to young men who are making preparation for a professional career.

**Table I—(Continued)**

| School Years Beginning | Total Students | Female Students Entered | M.D. |
|---|---|---|---|
| 1953 | 32 | 3 | 3 |
| 1954 | 32 | 0 | — |
| **Totals for School of Medicine** | | | |
| 1912-1954 | 1715 | 78 | 63 |
| Total for 1899-1954 | 1866* | 80 | 64 |
| 1955 | 31 | 3 | ? |
| 1956 | 31 | 1 | ? |
| 1957 | 41 | 2 | ? |
| 1958 | 40 | 3 | ? |
| Total for School of Medicine 1912-1958 | 1820* | 87 | |
| Grand Total 1899-1958 | 1971* | 89 | 64 |

*Note: These totals do not include an unknown number of male students who took the medical courses in the years before the organization of the College of Medicine.

### Conclusions

From a study of the data and from our personal knowledge concerning many of the women graduates, it seems evident that they have made a definite and useful contribution to the practice of medicine. The total of their professional activities is considerable and, as far as can be learned, the quality of their work is of a high order.

In considering the worth of women in the field of medicine, it ought not be said that they are useful in spite of the fact that they are women, but rather that they have a special area of usefulness because they are women. There are situations, both professional and nonprofessional, in which a woman perhaps is better suited than a man to give understanding service. It takes many different kinds of doctors in many kinds of professional situations to meet the needs of the many kinds of people.

**Table II**
**SUMMARY BY DECADES**

| Decades | Number Entered | M.D. Degrees | Married | Children | Deceased | Listed in AMA Directory 1958 | "Not in Practice" 1958 | Amount of Practice |
|---|---|---|---|---|---|---|---|---|
| Before 1900 | 1 | 1 | 0 | 0 | 1 | 0 | — | 1, 50 years. Full time. |
| 1900 to 1909 | 1 | 0 | — | — | — | — | — | — |
| 1910 to 1919 | 9 | 7 | 4 | 3 | 3 | 4 | 0 | 7, 28 to 40 years. Full time. |
| 1920 to 1929 | 11 | 9 | 6 | 11 | 2 | 7 | 1 | 6, 23 to 32 years. Full time.<br>3, Much less than full time. |
| 1930 to 1939 | 21 | 17 | 14 | 18 | 1 | 16 | 3 | 13, 15 to 23 years. Full time.<br>4, Interruptions. |
| 1940 to 1949 | 30 | 23 | 19 | 11 | 0 | 23 | 5 | 18, 4 to 14 years. Full time.<br>5, Interrupted or unknown. |
| 1950 to 1954 | 7 | 7 | 2 | 4 | 0 | 4 | 1 | 7, Internship and Residency Training |
| 1955 to 1958 | 9 | 0 | — | — | — | — | — | — |
| Totals | 89 | 64 | 45 | 47 | 7 | 54 | 10 | 52, Full time.<br>12, Interrupted.<br>64, Total Number. |

*. . . worry gives little things big shadows.*

ANON.

# Special Article

# A Hospital Network for Coal Miners And Their Families*

*Warren F. Draper, M. D.*

Not long ago, a German hospital administrator from a small industrial city near Frankfurt appeared at the office to arrange for a visit to our hospitals. He was traveling on an Eisenhower Fellowship and planned to visit some of our Memorial Hospitals as a highlight of his experiences in this country.

A short time later, the senior medical officer of the Oxford, England, Regional Hospital Board stopped in. He also had heard about our chain of ten hospitals in the mountainous Appalachian area and felt that his trip to this country would be incomplete without seeing at first-hand the work we are doing in caring for beneficiaries of the United Mine Workers Welfare and Retirement Fund.

Both have returned safely and, in addition to compliments paid to the hospitals and their staffs, they commented on having been in a geographical region of the United States that is seldom seen by tourists.

This area, where our hospitals are located, is roughly an oval approximately 250 miles long, extending from the high plateau at Beckley, West Virginia, southwesterly to the Kentucky and Tennessee border at Middlesboro. The territory is steeped in history of a particularly rugged sort, known first to Dr. Thomas Walker and Daniel Boone, who entered it through the Cumberland Gap.

At the turn of the century, tremendous reserves of soft coal were discovered in these mountains. The hills and valleys, so long isolated from the main stream of social and economic progress, suddenly began to change. Railroads, which had by-passed the region, built spur lines into the rich coal areas. Later, some of the trails that followed the streams and rivers through the narrow notches of the mountains were widened a bit for use as roads. By the time of the first World War there was a new economy here. It was based entirely on one industry: soft coal mining.


### *The Author*

- **Warren F. Draper, M. D., Executive Medical Officer, U.M.W.A. Welfare and Retirement Fund, Washington, D. C.**


Mining interests purchased enormous tracts of land, employed local people in the mines, and small communities grew up in the shadows of the coal tipple and mine portal. In many of them, the coal company built and owned houses, the general store, the school, and even the church building.

Medical care was a problem from the outset. The mining "camps," as the towns were called, had little to attract the physician wishing to establish a practice. The few hospitals were, for the most part, proprietary hospitals limited in capacity and facilities.

When, in 1948, the medical program of the Fund began its operation, the number of physicians and acceptable hospitals in the area was far from adequate to meet the needs. Local physicians had little opportunity to use modern techniques. Young physicians saw little future in these hills and valleys. Specialists in fields such as obstetrics and pediatrics were lacking in the area, although its population at that time was estimated to be around 800,000. After broad consultation and review by experts, we reluctantly came to this conclusion: if better hospitals and medical care were to be provided, the Fund would have to take the lead.

To provide for the establishment of these needed hospitals, not-for-profit corporations were organized in the three states—West Virginia, Kentucky and Virginia—to acquire the land and proceed with the building. These corporations were financed by funds of the Welfare and Re-

*Presented before the Annual Meeting of the Massachusetts Medical Society, in Boston, Massachusetts, May 20, 1959.
Submitted to the Publication Committee, August 28, 1959.

tirement Fund. The loans were secured by notes and mortgages on the physical properties of the three Associations. As the hospitals neared completion, a single corporation known as the Miners Memorial Hospital Association assumed their operation. The officers of this Association and its Board of Directors are personnel of the United Mine Workers Welfare and Retirement Fund.

Coincident with the start of these legal and organizational steps, sites for the construction of the chain of hospitals were selected. The geographic area to be served measured some 250 miles in length and the opportunity to build hospitals through this entire area offered many unique advantages. The hospitals were planned as an integrated system rather than as individual units, with a concentration of beds and specialized equipment in three larger hospitals located at Beckley, Williamson and Harlan, with bed capacities of 199, 143 and 192. Seven smaller hospitals of varying size from 50 beds at Pikeville, Kentucky, to 92 beds at Whitesburg also were built. These hospitals are not as completely equipped, and rely for the most part on the larger hospitals for special services. A good example of this is the concentration of roentgen therapy in the three larger hospitals. There was some thought at one time as to whether one or two larger hospitals would not suffice, but the travel difficulties for the patients made such a decision inadvisable.

Not only was it necessary to build complete general care facilities for the patients, but also the needs of the staffs had to be encompassed. Highly skilled specialists hesitated to open offices in these rural mining areas because of the capital outlay, the lack of adequate office space and the difficulty of point-to-point travel. To overcome these difficulties, doctors' offices were built into the hospitals and the supportive services such as laboratories, physical therapy, and x-ray, were designed to offer the advantages of group practice within the hospitals. The smaller hospitals have above average general care facilities but, as noted earlier, they rely on the three larger central hospitals for assistance in handling more difficult cases, either by having specialists coming to them or by transferring the patients to the central facilities. The concentration of difficult cases in the larger central hospitals makes it possible to provide a wide variety of skills and services which would not be possible in ten separate and independent units.

When construction was well under way, there was an intensive drive for the recruitment of a professional full-time salaried staff. Doctors from all parts of the country came to our Washington office or to the field offices in the mining communities, saw the framework of the hospitals and the framework of the program, and weighed the comforts of their present situations against the challenge of providing medical care in this isolated but industrial area.

Due to the paucity of hospitals in the area, a serious lack of laboratory technicians, nurses, dietitians, and even unskilled employees such as maids, janitors, firemen, and others in this area, required intensive recruitment as well as the projection of long-range plans for training many of such workers.

By the end of May, 1956, the ten hospitals were open and provided over 1,000 additional beds to an area where there were less than 2.5 beds per 1,000 beneficiary population.

Many physicians of high qualifications had joined with us, and ancillary staffs had been procured as skeleton groups. These were people from some of the finest teaching centers in the United States. Non-professional personnel were selected from the large number of local people who had applied for jobs. Their dedicated efforts resulted in making it possible for these hospitals to begin very active operation almost as soon as their doors opened and in 18 months all had been accredited by the Joint Commission. This, however, was only the beginning.

The labor supply situation in this area is the antithesis of that in urban areas. There is a great overabundance of unskilled hospital labor with seemingly 100 applicants for any job as maid, dishwasher, janitor, or dietary helper. Women have few opportunities to earn a living except perhaps as clerks in the five and ten cent stores or in other small shops. Only in recent years has there been any sizeable percentage of young men and women continuing their education completely through high school.

It was recognized that many nurses, laboratory technicians, and other skilled groups from urban centers were likely to be only transitory employees. The obvious solution, of course, was to train local people. Thus it is that at the Memorial Medical Center in Williamson, we have a school of practical nursing for men and women which, to date, has graduated approximately 200 licensed practical nurses. At Beckley, West Virginia, we have affiliated with the county vocational school for additional practical nursing training. Also at Beckley, there is a school of medical technology, a degree program affiliated with Concord College and Morehead State College. At the Harlan Memorial Hospital, there is a school of professional nursing as well as a

school for nurse anesthetists conducted by our staff anesthesiologists. All are accredited programs or in the process of becoming accredited.

Unlike the great medical teaching and research centers, the primary responsibility of our hospital network is patient care, especially the care of the coal miner, his wife and dependent children who are Fund beneficiaries. Education and research programs within our hospital system focus on improving the quality of care. Both formal and informal educational programs have been established, with residency training at the three central hospitals in the specialties of internal medicine, pediatrics and surgery. We enable and encourage staff physicians to attend state and national postgraduate courses and professional society meetings. Each hospital has budgeted funds to cover all or part of expenses of Association physicians attending such courses.

Guest lecturers of national and international repute are invited from time to time to discuss clinical problems of special interest. In addition to usual staff meetings in each hospital and meetings of members of particular services and committees, on occasion we hold regional meetings. The obstetrical chief of a central hospital, for example, meets with the obstetrical chiefs of the community hospitals which are geographically and functionally related to discuss obstetrical experience and problems encountered in their hospitals.

This educational pattern is not confined to the medical staffs. Dietitians, nurses, pharmacists, medical technologists, social workers, maintenance and other specially trained staff attend certain professional association meetings, workshops and institutes.

Clinical clerkships are another part of our educational program. Medical students who have completed their third year of study may serve a clinical clerkship of one to three months' duration. This includes participation in work-up and care of hospitalized and ambulatory patients, surgical and obstetrical assistance, attendance at staff rounds, staff departmental conferences, staff lectures, and seminars, and use of the medical libraries. The students receive an educational allowance during the clerkship.

We conduct an active research program but, again, the clinical studies and projects relate primarily to the medical care problems of coal miners and their families. Physicians participate as principal investigators or as co-workers with other physicians or in a multi-discipline team. The Association budget includes a limited amount of research funds. A physicians' committee is responsible for receiving, reviewing and recommending projects financed from these funds. Physicians are also encouraged to seek grants from outside sources and we have already undertaken one project with funds from the National Institutes of Health. At Beckley and at the Memorial Medical Center, additional construction funds have been secured through the U. S. Public Health Service for the construction of research facilities.

A thousand additional beds in this rugged rural mining area could not possibly provide all the medical care needed by the vast numbers of potential patients. The hospitals and the staffs can, however, help to raise the standards of medical care in the area. In this special sense they function as teaching hospitals. Each hospital has full-time chiefs of services. Each hospital has an active staff and a courtesy staff. The active staff is composed of full-time members who are employees of the Association and also non-full-time physicians in the community. The courtesy staff includes those physicians who desire staff privileges but who do not wish to attend medical staff meetings regularly nor to serve on committees. The hospitals, therefore, are open staff hospitals and welcome reputable licensed M. D.'s to staff appointments.

Inpatient services are but a portion of the Association's impact on the area. The ambulatory patient departments are seeing over 1,000 patients a day. The variety of problems seen here, as well as on the floors, disclose conditions that many physicians have encountered literally only in the textbooks.

A surgeon at one of the small hospitals recently summarized some of his observations over the past year or two. He is on the staff of a hospital in a small mining community which differs only slightly from the other nine hospitals, some larger and some smaller. Here are his comments:

> "We have been impressed with the large number of duodenal ulcers which we see at the hospital. It is not unusual to see duodenal ulcers in children 15 and 16 years of age. The number of perforated duodenal ulcers in females is outstanding. We find many pediatric peptic ulcers.
>
> "About trauma: In this field, we have the unusual opportunity of practicing military, traumatic medicine and surgery in a non-wartime period. These injuries are multiple thoracic, abdominal, and orthopedic traumatic problems. The compression fractures seen in this area must undoubtedly exceed those found in almost any other area except in an open wartime period.
>
> "Fractured pelves are common. Bad roads and high speed vehicles increase the amount of trauma seen here far beyond that noted by surgeons in other areas. In this hospital alone, we have performed 6 splenectomies in approximately three years.

"Respiratory problems far exceed those in any other area. The most interesting are our ever present problems of pneumoconiosis and emphysema. There are unlimited opportunities for future study and possible modalities in treatment. These occur in a comparatively young age group, with horribly advanced cases in the older age group, and they bring problems to the anesthesiologist and anesthetist. Parasitic infestation far exceeds, in our opinion, that found in Oriental countries where human fertilizer is used almost routinely.

"Gallbladder disease with cholelithiasis is extremely common and cholecystectomy has become one of our commonest operative procedures. It would be interesting to determine whether or not there is a relationship between the diet and gallbladder diseases. Scurvy and rickets rate far too high to be considered anywhere near the general average for the country and, until recently, there has been a strong reluctance on the part of the mining populace in most of the isolated areas to try new foods, either in the hospitals or in their homes."

Our experience to date has enabled us to observe the advantages of a full-time staff engaged in large scale group practice. We find that having all key personnel on the job or available day or night, contributes tremendously to the quality and quantity of care we can give our patients. We see the satisfaction which physicians derive from being able to secure consultations without delay, and to plan and carry out the diagnosis and treatment of the patient expeditiously. It has been gratifying to see patients learning to recognize and expect modern medical care—complete history, thorough physicals, diagnosis, specific treatment and follow-up. From their unsolicited comments we know they are coming to recognize the difference between bad, mediocre and quality care. We know that even though we are a centralized and integrated chain of hospitals, the quality of medical care cannot be imposed from the top. It must grow from within the individual hospital.

I would like to say that we have reached the ultimate in our medical care program, but we have not. The task of stepping in and taking the lead has many implications. What we have made is but a beginning. The hospital staffs, the central administration, and the officers of the Fund and the Association seek constantly to infuse our program with new and higher standards of performance. Much remains to be done and we must continue to progress, to move forward, for we are in a field where those who stand fall behind, those who walk can barely keep up and only those who run can lead.

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# The Chronic Disease Laboratory in PH

In a time when the triumphs of technology have literally made real many of man's most fanciful dreams, I may be pardoned if I venture some bold ideas about the future of laboratory work in public health.

I honestly believe that we shall live to see the time when laboratory tests will penetrate the mysteries of the chronic diseases. I believe that, ultimately, laboratories will be able to identify most, if not all, of the leading chronic diseases through simple, valid tests that will be economical to perform.

For example, the "fingerprints in the blood" which we are only beginning to understand may eventually reveal through the analysis of a single blood sample the presence or absence of a whole array of chronic conditions. Most important, such future testing can detect the presence or even the threat of a chronic disease in ample time to heed the warning.

Medical science, by its conquest of the infectious diseases, has not ended an era. Rather, it has opened an even greater era, which will be known in history for victories won over the chronic diseases. And, as in years gone by, laboratories again will be the shock troops in the attack that has now commenced.—Albert L. Chapman, M. D., in Public Health Reports.

# The President's Page

## The Forand Bill

THERE has been much discussion of the proposed Forand Bill and its features regarding compulsory health insurance protection for our sixteen million people above age sixty-five, many of whom now have their own private program for retirement and are well able to afford it with judicious planning. This number includes the 43 per cent who would have their voluntary medical and hospital insurance plans completely destroyed by passage of the Forand Bill.

Complete annihilation of the entire voluntary health insurance plan of the general public, to the benefit of only the older segment of it, creates a grave concern in the mind of every doctor alive to the needs for socio-economic security for his patients, his family, and himself.

The basic faults of the Forand Bill, besides its high cost, are as follows: (1) Care for the older citizens calls for a cooperative attack on the problem by nurses, doctors, hospitals, social workers, insurance companies and community leaders. It requires flexibility of medical approach and technique, not the rigidity inherent in government controlled programs. The Forand Bill is simply bad medicine; (2) It is a political approach to a health problem developed by non-medical people; (3) A nationalized program of this sort would weaken the patient-physician relationship; and (4) Political abuses and administrative wastes would be predictable.

Every doctor in West Virginia should familiarize himself with the material available on this much discussed issue and then use it in a "Person to Person" approach such as that urged by Mr. Drew Pearson when he appeared at the splendid Potomac-Shenandoah Valley Postgraduate Institute held in Martinsburg, October 16-18, 1959. People will listen to their doctor discuss medical issues and heed his sincerity when they know his concern is for everyone.

Now where can we get this information? The American Medical Association has made available to each physician and each medical society ample material and I urge each one of you to become informed. The pamphlet, *The Forand Bill . . . And What You Should Know About It,* is accurate, informative and easy to read. It is available through your local society.

The president of the American Medical Association, Dr. Louis M. Orr, urges us to "discuss this legislation with friends, with patients, and others with whom we come in contact . . . It would be greatly helpful if each doctor would assume the specific responsibility of making certain that 10 acquaintances are familiar enough with the bill to write letters to their own Congressmen telling them why they believe the Forand Bill is bad for them, bad for the nation."

It would appear to me that much too often we physicians are *against* various issues, in the guise of socialized medicine, and fail to assume our responsibility in community leadership and propose solutions for these local problems. If these problems were solved on a local level then there would be no necessity for legislation out of Washington to attempt to meet the medical needs of our senior citizens. We *must* accept this responsibility with a *positive* approach.

We can encourage those past sixty-five to continue productivity. They need an opportunity to be useful. They need a helping hand, not a handout, in an effort to remain self reliant.

For those who are ill or incapacitated, it behooves us as individual physicians to give freely of our services and lend a guiding hand in providing adequate insurance programs, on a voluntary basis, at a price they can afford and thus maintain their self sufficiency.

J. C. Huffman, M. D., President

# THE WEST VIRGINIA MEDICAL JOURNAL

*Official Organ of the West Virginia State Medical Association*

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.



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*Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.*

*Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.*


# EDITORIALS

## A STAMP FOR EPHRIAM

Not only is December 25th the birthday of The Christ, The Savior of Mankind, and of the Christian Religion, but it is likewise the natal day of ovariotomy and of abdominal surgery. The Christmas Day just past was the sesquicentennial of Ephriam McDowell's daring pioneer operation upon Jane Todd Crawford in 1809. We follow Flexner in "Doctors on Horseback" as to the exact date of the operation for he apparently gave much study to that phase of the subject. Mrs. Valentine (McDowell's granddaughter) in one place in her biography of her grandfather, gives December 13 as the day Doctor McDowell saw Mrs. Crawford in consultation with two local doctors at her home, and in at least two other places she gives the actual date of the operation as December 13 instead of Christmas Day; confusing and actually contradictory language. Her first statement must have been correct because Mrs. Crawford had to ride sixty miles on horseback and rest a few days while being prepared for operation and it is as well established as any date in early Kentucky history that the actual operation was performed on Christmas Day.

The local physicians had made a diagnosis of intra-abdominal pregnancy which, incidentally, was not such a bad diagnostic guess in that day of primitive medicine. However, on bimanual examination, McDowell was able to assure himself that the corpus uteri was not enlarged and that it was separate and distinct from the mass distending the abdomen. Therefore, he reached the correct conclusion that the actual pathology was an ovarian tumor.

Mrs. Crawford's suffering was intense. Doctor McDowell discussed the condition with her and told her that he would operate upon her and remove the tumor if she would permit him. He told her also that the operation had never been done before and that all doctors had declined to undertake it for fear of a fatal outcome. He explained to her, however, that ignorant laymen often spayed bitches and sows and that very rarely did a death result and that what he planned to do actually amounted to spaying her and the risk was not much more in a human being than in the lower animals.

Evidently his earnestness and his bedside manner induced in the patient complete confidence and provoked a good doctor-patient relationship, for Mrs. Crawford agreed to make the sixty-mile trip to Danville and to undergo the operation.

Ephriam McDowell was a religious man and depended upon Almighty God to guide him. He chose Christmas Day to operate because he felt that on Christ's birthday the prayers of all the world would, in Flexner's words, "create a propitious atmosphere." Certainly the prayer he made for Divine guidance in the operation, which he wrote down, was both majestic and eloquent.

The bravery of this pioneer backwoods surgeon cannot be questioned. The operation was opposed by practically all the population of that area and in fact, was looked upon as deliberate murder. He knew that the mob waiting outside his office already had a rope over the limb of a tree to hang him if the patient succumbed, but their anger changed to cheers when they learned she lived. Nor can the bravery of Jane Crawford be discounted. She was strapped to the table and had only a few opium pills as an analgesic. When she knew the incision was about to be made, she began singing a hymn and continued hymn-singing throughout the operation but with lessening vigor.

Mrs. Crawford was evidently the first patient to practice early ambulation, for on the fifth post-operative day, McDowell found her up making her bed, and not inclined to desist from household chores at his bidding. However, by dint of threats and persuasions, he induced her to remain inactive until the 28th day when she mounted her steed and rode back home to take up her former household duties, and she remained well until her death at seventy-nine.

Some medical historians have not been too kind to McDowell but perhaps this is due to his poor records, for certainly he wielded his pen far less deftly than his scalpel. Williams in his "Biographies of Eminent Deceased Physicians" does not list this pioneer surgeon, and Dana, comparatively recently, in "The Peaks of Medical History" makes no mention of him nor does he list in his index either of the terms "ovariotomy" or "laparotomy." If the achievement of McDowell in the primitive Kentucky wilderness did not constitute a "peak of medical history," we are at a loss to comprehend the meaning of the phrase "peak of history." Most modern medical historians, however, give McDowell the credit due him, and the monument erected by the Kentucky State Medical Society at Danville in 1879 perpetuates his memory.

McDowell studied in Edinburgh in 1793-95, but was economically unable to stay long enough to secure a degree. He apparently developed materially during his stay in Scotland, for Samuel Brown, a fellow student, is credited with the remark that McDowell went to Scotland a gosling and returned a gander. The only academic degree he ever had was an honorary M.D. bestowed upon him by the University of Maryland in 1825, long after he had become famous.

By all criteria, McDowell was a great man and a great benefactor of humanity. He was a clear thinker, an intrepid surgeon, a hard worker, and he knew his anatomy. His operative achievements were a beacon lighting the future of abdominal surgery.

Any shortcomings at recognition by medical historians may have just been atoned for, however. The Post Office Department has issued a memorial stamp commemorating the sesquicentennial of the first ovariotomy and the man who performed it and thereby conferred a blessing on humanity and especially on suffering womanhood. May the stamp make McDowell's name and work known to the masses and not deteriorate into just another "must" for the philatelist.

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## WOMEN IN MEDICINE

Elsewhere in this issue appears an article which concerns the number of women enrolled in the West Virginia University School of Medicine from 1902 to 1958. The authors of this article are in the enviable and unique position of having taught nearly all of these students, and those they have not taught (with one or two exceptions) they knew personally. It is unlikely that in any other medical school two men could be found who could make such a personal study.

The coincidence is, of course, that the authors of this article have for a long time been associated with the West Virginia University School of Medicine, which was organized in 1902. For the main part, the classes have been small. Another factor is that during the first ten years of the School's existence only one woman student matriculated.

The authors emphasize that the matter of women in medicine is a controversial issue. There are some who feel that women should not be allowed to enroll in a medical school. If the argument is used that only those students should be admitted who potentially can give the most and longest service to the practice of medicine, obviously but few women could compete with men. The validity of such a premise, however, is surely debatable.

The authors point out that the percentage of women enrolled in West Virginia University School of Medicine throughout the years represents only 4.52 per cent of the total enrollment. In this connection it is of interest that the average for 1957-58 for all medical schools was 5.57 per cent. This is relatively a low average. Incidentally it would be of interest to see what the percentage of women students will be during the next decade.

The authors definitely feel that there is a place for women in medicine. The article ends on an

optimistic note. The authors in their conclusion state that there are situations, both professional and nonprofessional, in which a woman is perhaps better suited to give understanding service than is a man, and that it takes many different kinds of doctors in many kinds of professional situations to meet the needs of the many kinds of people.

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**ANOTHER GENEROUS CONTRIBUTION TO SCHOLARSHIPS FUND**

A news story appears elsewhere in this issue of *The Journal* concerning the contribution by the Medical Arts Supply Company of Huntington of the sum of $500 to the Medical Scholarships Fund of the West Virginia State Medical Association. Thus, this West Virginia firm has for the second consecutive year added substantially to the Fund from which medical scholarships are being awarded to West Virginia students at the University.

Our information is that the current recipients of the award, which is worth $1,000 per annum for the four years in which the student is enrolled in the WVU School of Medicine, are both showing marked ability in handling their assignments in school. These boys, Larry Hemmings of Charleston and Terry Tallman of Alma, have the best wishes of all the members of the West Virginia State Medical Association, who will watch with more than passing interest their progress in preparing themselves for a career in medicine.

Thanks again to the Medical Arts Supply Company for another most generous contribution to the Medical Scholarships Fund.

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**UNCLE SAM'S 'GIFTS' MOUNTING**

Yes, there is a Santa Claus. Uncle Sam probably knows more about Santa than anyone else. Sam's been fattening his bag each year with gifts from the American people in the form of increased taxes and steadily rising Social Security rates. Let's take a look.

Your Social Security tax went up again on January 1.

How much it went up depends on your earnings and whether you work for yourself or somebody else.

If you work for someone else, your tax will be 3 per cent of all your earnings up to $4,800. It has been 2½ per cent of your earnings up to $4,800.

The increase—in dollars and cents—means you will have to pay $144 tax in 1960 if your earnings are $4,800 or more, compared with $120 in 1959.

Whatever your tax is your employer will have to match it.

If you work for yourself—that is, you're self-employed—and you're covered by Social Security, your tax for 1960 will be 4¼ per cent of your net earnings up to $4,800. It has been 3¾ per cent of $4,800 a year.

This means, if your earnings are $4,800 or more in 1960, you will have to pay a tax of $204, compared with $180 in 1959.

Remember: If you are self-employed, you pay the Social Security tax only once a year at income tax time. The tax paid then is for your previous year's earnings.

For example: Between January 1 and February 15, 1960 you will pay your Social Security tax. Since the tax will be for your 1959 earnings, it will be at the 3¾ per cent rate on your earnings up to $4,800. It won't be until you pay tax in 1961—for your earnings in 1960—that you will have to pay the new 4¼ per cent tax.

The January 1 rise in tax will not be the last. Under the present law, it will be raised again in 1963 and every three years after that until a final jump in 1969. There will be even more raises if other changes are made by Congress in the Social Security Laws. Specifically, the Forand Bill, if enacted, would raise the Social Security Tax at least another ½ of one per cent in order to provide hospital and medical care under "Social Security."

Here is a table of the present scheduled increases:

Years* 1960-62; Employee 3 per cent; Employer 3 per cent; Self-Employed 4¼ per cent.

1963-65; Employee 3½ per cent; Employer 3½ per cent; Self-Employed 5¼ per cent.

1966-68; Employee 4 per cent; Employer 4 per cent; Self-Employed 6 per cent.

1969 and after, Employee 4½ per cent; Employer 4½ per cent; Self-Employed 6¾ per cent.
—*West Virginia Farm News.*

*The percentages apply to earnings up to $4,800.

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He is great who feeds the minds of others. He is great who inspires others to think for themselves. He is great who pulls you out of your mental ruts, lifts you out of the mire of the commonplace, whom you alternately love and hate, but whom you cannot forget.—Elbert Hubbard.

# GENERAL NEWS

## Dr. E. Vincent Askey To Speak At 93rd Annual Meeting

The Program Committee of the West Virginia State Medical Association has announced that Dr. E. Vincent Askey of Los Angeles, California, who will be installed as president of the American Medical Association at the annual meeting in Miami Beach in June, will be among the guest speakers at the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

E. Vincent Askey, M. D.

Dr. Seigle W. Parks of Fairmont, the chairman, said that Doctor Askey has accepted an invitation to be the guest speaker before the final session of the House of Delegates on Saturday afternoon, August 27.

Doctor Askey, who has had a long, interesting and successful career in medicine, has been serving as AMA president elect during the current year following his election at the 1959 annual meeting in Atlantic City.

He is a native of Sligo, Pennsylvania, and is a past president of the Los Angeles County Medical Society and the California State Medical Association. He also served for several years as speaker of the AMA House of Delegates.

### Program Committee Busy

The Program Committee has been busy since the final day of the 1959 meeting making plans for the 93rd Annual Meeting in August. The Committee held its first formal meeting at the West Virginia University Medical Center in Morgantown on December 12, and another meeting was to be held at the home of Dr. and Mrs. J. C. Huffman in Buckhannon on January 31.

In addition to Doctor Parks, the other members of the Committee are Drs. Theresa O. Snaith of Weston, G. Thomas Evans of Fairmont, and William A. Thornhill, Jr., and Kenneth G. MacDonald, both of Charleston.

The Committee announced that general scientific sessions will be held on Thursday, Friday and Saturday mornings, August 25-27. As usual, meetings of the Association's sections and affiliated societies and associations will be held during the afternoon hours.

The Committee is busy contacting potential speakers for the scientific sessions and once again some of the leading physicians and surgeons in the country will be among the list of guest speakers. The completed scientific program will be announced several months prior to the meeting.

### Two Sessions of House of Delegates

The Association's House of Delegates will meet twice during the meeting. The first session will be held on Wednesday evening, August 24, and the second session on Saturday afternoon, August 27.

Dr. J. C. Huffman of Buckhannon, the president, will deliver his presidential address before the first session, and Doctor Askey will speak before the second session.

### Entertainment Program by Auxiliary

The entertainment program at the convention will be presented by the Woman's Auxiliary, and Friday evening was left open for the main entertainment feature for physicians, their wives and guests.

The entire convention program will be presented in the air-conditioned convention unit of The Greenbrier. More than 60 scientific and industrial exhibits have been booked and will be set up in the beautiful Chesapeake Hall.

Additional information concerning the convention at The Greenbrier will appear in future issues of *The Journal*. The complete program will appear in the issue for August.

### Make Your Reservation Now!

Members of the West Virginia State Medical Association are urged to make reservations without delay for accommodations during the 93rd annual meeting at The Greenbrier in White Sulphur Springs, August 25-27, 1960. Application forms for room reservations were enclosed in a bulletin mailed to each member last month. The completed forms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, West Virginia.

## BS Enrollment Passes 44 Million Mark

The National Association of Blue Shield Plans reported early in January that more than 1,600,000 persons enrolled in the 73 Plans in North America during the first nine months of 1959. The nine-month enrollment gain for 1959 reflects a substantial improvement over the 244,673 gain for the corresponding period during 1958.

Total membership in the various Blue Shield Plans reached a total of 44,214,441 as of September 30, 1959, which represents an enrollment of nearly 24 per cent of the total population of the United States.

## PG Course on Fractures and Trauma

The Fourth Postgraduate Course on Fractures and Other Trauma, sponsored by the Chicago Committee on Trauma of the American College of Surgeons, will be held at the John B. Murphy Memorial Auditorium in Chicago, April 27-30.

Prominent speakers will lead discussions on all phases of trauma: injuries to the eye, face, neck, chest, abdomen and extremities; repair of bone and cartilage in trauma; aseptic necrosis; urological complications of fractures; intramedullary fixation of fractures; bone grafts; and other related subjects.

The registration fee is $50. Further information may be obtained by writing to the program chairman, John J. Fahey, M. D., 1791 W. Howard Street, Chicago 26, Illinois.

## College of Medical Evangelists Arranges PG Convention

The 28th Annual Alumni Postgraduate Convention of the College of Medical Evangelists will be held at the Ambassador Hotel in Los Angeles, February 28-March 3.

The five-day meeting will feature six guest lecturers, a prominent Los Angeles attorney and several members of the faculty from the USC, UCLA, and CME Schools of Medicine.

Physicians registered for the course will receive Category I credit from the American Academy of General Practice.

Full information concerning the convention may be obtained by writing Mr. Norman Spuehler, The College of Medical Evangelists, 1720 Brooklyn Avenue, Los Angeles.

## Dr. Seabury Heads Southern Chapter, ACCP

Dr. John H. Seabury of New Orleans was elected president of the Southern Chapter of the American College of Chest Physicians at the recent annual meeting of that group in Atlanta, Georgia.

Other new officers are as follows: Dr. DeWitt C. Daughtry, Miami, Florida, first vice president; Dr. Henry R. Hoskins, San Antonio, Texas, second vice president; and Dr. Joseph W. Peabody, Jr., Washington, D. C., secretary-treasurer.

**Members of the Program Committee named to make arrangements for the 93rd Annual Meeting at The Greenbrier in White Sulphur Springs, August 25-27, are shown at a recent meeting of that group held at the WVU Medical Center in Morgantown. Seated at the table are, left to right, Dr. Theresa O. Snaith of Weston, Dr. Seigle W. Parks of Fairmont, the chairman, and Dr. Kenneth G. MacDonald of Charleston. Standing, Dr. William A. Thornhill, Jr., of Charleston, and Dr. G. Thomas Evans of Fairmont.**

## Status of Foreign Graduates Changed Under New MLB Regulations

The West Virginia Medical Licensing Board has liberalized the requirements for service by foreign educated physicians in state institutions. This action was taken at the winter meeting of the Board held in Charleston on January 11.

Governor Cecil H. Underwood, in his call for the Legislature which convened on January 13, proposed that legislation be enacted governing the employment of foreign trained physicians in the state institutions.

### Certain Permits Renewable Indefinitely

Under the revised regulations, foreign trained physicians will now be permitted to practice in state hospitals and institutions for a period of one year with the understanding that permits issued may be renewed indefinitely.

Temporary authorizations for foreign graduates entering West Virginia for internships or residencies will be granted providing such graduates fulfill all the requirements of the Board as stipulated in the regulations, and provided further that they agree to appear in person at the next meeting of the Medical Licensing Board.

The revised regulations now require all foreign graduates to submit their medical credentials to the Board for evaluation by the proper agencies. Such graduates serving in state institutions will be required to take the regular licensing examination as soon as they become eligible.

The Board made it clear that no part of the revised regulations shall conflict with any West Virginia law which requires regular licensure for any State position.

### Eight Physicians Receive Permits

At the meeting of the Board on January 13, eight physicians affected by the new regulations appeared and were issued one-year permits to serve in mental hospitals, tuberculosis sanitoria, or the state's emergency hospitals at Welch or Fairmont.

Doctor Dyer said that authority for issuing the permits is covered in a section of the law relating to "emergency areas where there is a great need for physicians." He said that the state hospitals and institutions were declared to be "emergency areas."

Before the regulations were revised, graduates of foreign medical schools were permitted to work, under supervision, as residents and interns in hospitals for not more than four years. Most of the applicants who appeared before the Board were given permits to engage in the four-year program, the exception being the eight who were authorized to accept work in state institutions.

### Status of Other Applicants

It was explained that four or five other applicants were not given four-year permits because of the fact that their records show that they have already obtained the training they would get as interns and residents; however, they will be eligible to apply for the one-year renewable permits to practice as physicians in the state hospitals and institutions.

## Community Health Study Undertaken By Local Health Departments

Dr. N. H. Dyer, State Director of Health, has announced that an exhaustive study of health facilities, resources and possible needs has been undertaken by county health departments throughout the state.

He said the program was launched at a joint staff conference held recently in South Charleston and attended by 64 persons representing local health units.

Basic to the survey is the "Guide to a Community Health Study," a 64-page questionnaire, published by the American Public Health Association and designed to elicit data in the following six areas: community resources, maternal and child health, health of school children, adult health, disease control, and environmental health.

Local health officers have been requested to complete the study by March 15, so that information obtained will be available for planning programs for 1960-61.

Doctor Dyer said the survey will enable local health officials to evaluate resources in their own areas and to compare them with standards recommended by the APHA.

"When the data have been evaluated," he said, "we are confident we will have developed greater insight into particular problems in specific areas of the state. This will enable us to point out deficiencies in the program, if any, and to plan for remedial action."

Doctor Dyer said the survey will also reveal many population characteristics of the counties, such as the number of physicians, dentists, nurses and other professional personnel per capita as compared with national averages and accepted standards.

"Another advantage," he said, "will be that we can determine how much assistance is coming from allied agencies, both official and voluntary."

## Film on 'Congestive Heart Failure' Available for Local Showings

A new sound film, "Congestive Heart Failure," is now available for showings before lay groups, nurses, medical students and pharmacists, and for use on local television.

The 16-mm color film was produced by Merck Sharp & Dohme and has the approval of the American Medical Association. Technical advice was furnished by Dr. William D. Stroud, professor emeritus in cardiology, Graduate School of Medicine, University of Pennsylvania.

The film uses animation to acquaint the victims of this disease with the normal functions of the heart and what happens to it under stress. Animation tells the story of a weakened heart reacting to excessive demands.

The film may be obtained for local showings by writing to the AMA Film Library, 535 N. Dearborn Street, Chicago 10, Illinois, or the Merck Sharp & Dohme Film Library, Merck Sharp & Dohme, Philadelphia 1, Pennsylvania.

## Regional Conference on Aging In Baltimore, March 30-31

One of four regional conferences on aging, sponsored by the American Medical Association, will be held at the Southern Hotel in Baltimore, March 30-31. Six medical associations will co-sponsor the Baltimore meeting. These include West Virginia, Virginia, Maryland, Delaware, New Jersey and the District of Columbia.

Dr. Frederick C. Swartz of Lansing, Michigan, chairman of the AMA Committee on Aging, has announced that the conference will be attended by representatives of agriculture, industry, labor, health professions, churches, schools, business, government, women's organizations, communications media, and civic organizations.

In announcing plans for the conference, Doctor Swartz said, "We need to explore the opportunities for positive health and meaningful living among older people through exercise of individual, group and community initiative. With nine per cent of the nation's population now over 65 and the percentage increasing, it is important for every American to give thoughtful consideration to the aging process and its implications —to individuals and society alike."

According to Doctor Swartz, specific objectives of the conference are as follows:

(1) To appraise the significance of the longer life span and its impact on individuals and society.

(2) To analyze relationships between social, economic, psychological, and physiological factors and the health of older persons.

(3) To realistically explore the opportunities and needs created by a growing population of older persons, and

(4) To assess responsibilities of the individual and of both medical and non-medical groups in dynamic approaches to the new era of aging.

Regional conferences also have been planned in San Francisco, New Orleans and Atlanta. The San Francisco meeting was held in January and the others will be held during February and March.

## Medical Arts Supply Contributes Again To Medical Scholarships Fund

The Medical Arts Supply Company of Huntington has for the second consecutive year contributed the sum of $500 to the Medical Scholarships Fund of the State Medical Association.

The Fund is used for medical scholarships awarded annually to a member of the freshman class in the West Virginia University School of Medicine.

Two scholarships have already been awarded under the program, one to Larry Hemmings of Charleston, and the other to Terry Tallman of Alma, Tyler County. The scholarships are for $1,000 per annum for the four years spent as a student in the WVU School of Medicine.

## Preliminary Plans Completed For Oph. and Otol. Meeting

Preliminary plans have been completed for the annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, which will be held at The Greenbrier in White Sulphur Springs, April 10-12.

Dr. N. K. Joseph of Wheeling, the president, has announced that the following physicians have accepted invitations to appear as guest speakers during the three-day meeting:

Harold G. Scheie, M. D., Professor of Ophthalmology, University of Pennsylvania School of Medicine, Philadelphia; Charles E. Iliff, M. D., Associate Professor of Ophthalmology, Johns Hopkins University School of Medicine, Baltimore; and Oscar T. Becker, M. D., Clinical Associate Professor of Otolaryngology, University of Illinois College of Medicine, Chicago.

Further information concerning the program may be obtained by writing to the secretary, Albert C. Esposito, M. D., First Huntington National Bank Building, Huntington 1, W. Va.

## Doctor Callender State Chairman Of ACS Trauma Committee

Dr. George R. Callender, Jr., orthopedic surgeon of Charleston, has been appointed West Virginia Chairman of the Trauma Committee of the American College of Surgeons. He will work with the ACS Committee and with chairmen who have been appointed for the various other states.

### Change in Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston 24, West Virginia.

## Frank E. Bunts Annual PG Course In Cleveland, Feb. 10-11

The Seventh Annual Postgraduate Course of the Frank E. Bunts Educational Institute will be held in the auditorium of the Cleveland Clinic, February 10-11, 1960. The Institute is affiliated with the Cleveland Clinic Foundation and the postgraduate continuation course will be sponsored by the Cleveland Chapter of the American Academy of General Practice.

It has been announced that the course, which will be open to all members of the medical profession, is acceptable for ten hours category 1 credit by the AAGP.

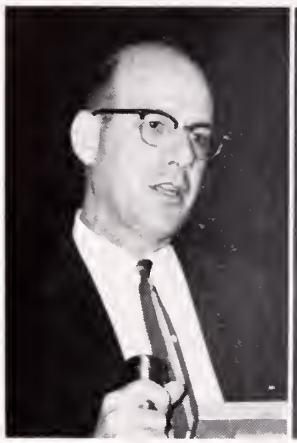
The registration fee is $20.00, and check for $5.00 should be enclosed with advance registration. Registration is limited to 150, and acceptances will be made in the order of receipt of applications.

Full information concerning the course may be obtained by writing to the Educational Secretary, The Frank E. Bunts Educational Institute, 2020 E. 93rd Street, Cleveland, Ohio.

## C. Joseph Stetler Guest Speaker At Meeting in Parkersburg

C. Joseph Stetler of Chicago, director of the Law Division of the American Medical Association, was the guest speaker at the annual joint dinner meeting of the Parkersburg Academy of Medicine and the Woman's Auxiliary which was held at the Chancellor Hotel in Parkersburg on January 7.

Dr. J. C. Huffman of Buckhannon, president of the West Virginia State Medical Association, and Mrs.



J. C. Huffman, M. D.

Jack J. Stark, M. D.

Robert R. Pittman of Marlinton, president of the State Auxiliary, also were guests and spoke briefly.

Mr. Stetler stated that the Forand Bill, which is pending in the Ways and Means Committee of the House of Representatives, "is a political approach to a health problem, designed and developed to be administered by non-medical people under a system in which bureaucratic abuse and administrative waste are inevitable."

He said the bill represents a fundamental deviation from the basic concept of the social security system which is meant to provide cash benefits, not services. "It injects the federal government into the physician-patient-hospital relationship and would result in the deterioration in the quality of medical care."

Mr. Stetler said the "strongest objections to the bill, however, are that it is unnecessary, it would not take care of the indigent and would result in poorer, not better, health care for the aged."

In addition to his appearance before the physicians and their wives, Mr. Stetler was a guest on a local television show prior to the meeting. His address was also recorded for presentation on radio the next day.

Dr. Jack J. Stark, the president, presided at the meeting which was attended by more than 100 persons.

### Relocations

Dr. Stephen Mamick of White Sulphur Springs, former secretary of the Mingo County Medical Society, is now serving a fellowship in radiologic pathology at the Armed Forces Institute of Pathology in Washington, D. C. His present address is 12811 Holdridge Road, Silver Springs, Maryland.

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Dr. Harold G. Young, a veteran of 31 years' service as a surgeon in the Navy, who retired last year with the rank of Rear Admiral, has opened offices in Morgantown where he will engage in the practice of general surgery. He has offices in the Monongahela Building.

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Dr. Ralph Frazier of Logan has moved to Fayetteville where he will continue the practice of his specialty of surgery. He has offices at 110 Wiseman Avenue.

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Dr. Joseph G. Doboy, formerly of Longacre, who has completed a three-year residency in diagnostic and therapeutic radiology and istotopes at the University of Virginia Hospital in Charlottesville, has accepted appointment as director of the Department of Radiology at Fairmont General Hospital. His family will join him in that city within the next few weeks.

C. Joseph Stetler of Chicago, director of the AMA Law Division, is shown speaking before a joint meeting of the Parkersburg Academy of Medicine and the Woman's Auxiliary, which was held in Parkersburg on January 7. Others at the speaker's table are, left to right, Mrs. J. C. Huffman of Buckhannon, a past president of the State Auxiliary; Dr. J. C. Huffman, president of the State Medical Association; Dr. Jack J. Stark, president of the Parkersburg Academy of Medicine; Mrs. Stark; and Mrs. R. R. Pittman of Marlinton, president of the State Auxiliary.

## Medical Meetings, 1960

The following is a partial list of national, state and district medical meetings scheduled for 1960:

Feb. 4—"West Virginia Day" Observance, Clarksburg.
Feb. 28-Mar. 4—Am. Coll. of Allergists, Bal Harbour, Miami Beach, Fla.
Mar. 21-24—American Academy of General Practice, Philadelphia.
Apr. 1-2—W. Va. Chap., ACS, White Sulphur Springs.
Apr. 4-8—ACP, San Francisco.
Apr. 10-12—W. Va. Acad. Oph. & Otol., White Sulphur Springs.
Apr. 29-30—W. Va. State Society of Technologists, Charleston.
May 6-8—W. Va. Chap. AAGP, Charleston.
May 12-13—W. Va. PH Assn., Bluefield.
June 13-17—AMA Annual Meeting, Miami Beach, Fla.
**Aug. 25-27—93rd Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.**
Sept. 13-15—National Cancer Conf., Minneapolis.
Sept. 14-16—Southern Trudeau Soc., Charleston, S. C.
Sept. 22-24—W. Va. Hospital Assn., White Sul. Springs.
Oct. 21-23—PG Institute, Martinsburg.
Oct. 31-Nov. 3—Southern Medical, St. Louis.
Nov. 29-Dec. 2 — AMA Clinical Meeting, Washington, D. C.

### Auto Emblems Available

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

## County Societies CD Conference In Chicago, Nov. 5-6

The Eleventh Conference of County Medical Societies Civil Defense Organization, sponsored by the AMA Council on National Defense, will be held at the Palmer House in Chicago, November 5-6, 1960.

A general invitation has been extended to state and county medical societies to have representatives at the Conference. The program for the two-day meeting will be tailored specifically for the information and guidance of state and county medical society committees on emergency medical service and civil defense.

## Dr. Randolph L. Anderson Honored By American Orthopaedic Assn.

Dr. Randolph L. Anderson of Charleston has been honored by being named a member of The American Orthopaedic Association, which is the senior society of the field in the country.

The purpose of the Association is the advancement of knowledge and the care of the disabled "and in the furtherance of teaching and research in orthopaedic and allied fields."

The first meeting of the Association was held in 1887 and in subsequent years its membership has included many of the outstanding men in orthopaedic surgery in this country and in Canada, and its roster of corresponding members includes leaders in that field in many foreign countries of the world. The 1959 roster shows a total of 297 members.

## AMA Rural Health Conference In Grand Rapids, Feb. 25-27

"Meeting Challenges with Responsibility" is the theme for the 15th National Conference on Rural Health which will be held at the Pantlind Hotel in Grand Rapids, Michigan, February 25-27.

The conference is sponsored annually by the Council on Rural Health of the American Medical Association, in cooperation with state medical associations, national farm groups, agricultural leaders and allied organizations.

The program for the three-day meeting will highlight discussions on basic food habits, food fads and fallacies, modern health techniques, careers in the field of medicine, and life-span immunization. There will be several panel discussions with active audience participation.

Dr. E. Vincent Askey of Los Angeles, California, president elect of the American Medical Association, will be the speaker at the banquet on Friday evening, February 26.

Further information concerning the program may be obtained by writing to Miss Arline Hibbard, Secretary, AMA Council on Rural Health, 535 N. Dearborn Street, Chicago 10, Illinois.

## W. Va. Chapter, ACS, Sponsors Clinic in Wheeling, Jan. 16

More than 30 members of the West Virginia Chapter of the American College of Surgeons attended a one-day scientific session held at the Ohio Valley General Hospital in Wheeling on January 16. Registration was held at Wilson Lodge in Oglebay Park on Friday evening, January 15.

An operative clinic was presented at the hospital on Saturday from 8 A. M. until noon, with Dr. Charles D. Hershey in charge. Following a luncheon in the Doctors' Dining Room, the afternoon session was devoted to the presentation of seven cases, with Dr. J. O. Rankin in charge.

A social hour and dinner at Wilson Lodge rounded out the program. Dr. Kenneth G. MacDonald of Charleston, president of the Chapter, stated at that time that plans are being made for a similar scientific session to be held in another city later this year, or early in 1961.

He also announced that plans have just about been completed for the annual meeting which will be held at The Greenbrier in White Sulphur Springs, April 1-2.

### License Revoked

The license of Dr. Harold Buster Young of St. Mary's to practice medicine and surgery in West Virginia has been revoked by the Medical Licensing Board. This action was taken at the winter meeting of the Board in Charleston on January 11.

It may be that the race is not always to the swift, nor the battle to the strong—but that's the way to bet.—Damon Runyon.

## State Vital Statistics Report Shows 44,428 Babies Born in 1958

A summary of birth and death statistics for 1958 shows that there were 44,428 resident live births, giving the state a birth rate of 22.6 per 1,000 population. The national figure for the same period was 24.3. West Virginia's average for 1958 represents a slight increase over the preceding year when 44,362 births were reported with a rate of 22.4.

Dr. N. H. Dyer, state director of health, has pointed out that this state continues to retain a birth rate that compares favorably with the national average, even though total births have declined substantially during the past several years.

In Doctor Dyer's report which covers the calendar year 1958, it is shown that male births exceed female births by three per cent. Of the total births, 94.6 per cent were white and 5.4 per cent non-white. Physicians were in attendance at 98.6 per cent of deliveries, midwives at .9 per cent, and others at .5 per cent.

### Most Deliveries in Hospitals

Most of the deliveries were in hospitals, accounting for 42,383 live births or 95.4 per cent of the total. In emphasizing the importance of the high percentage of hospital deliveries attended by physicians, Doctor Dyer cited the development as desirable and an important factor in reducing maternal and infant mortality rates.

### Death Rate Lower Than National Average

West Virginia's infant death rate for the year 1958 was 26.1 per 1,000 live births, somewhat lower than the estimated national average of 26.9.

There were 20 deaths from maternal causes with a rate of .4 per 1,000 live births. The estimated maternal death rate for the nation is projected at .35, but this figure does not necessarily indicate that West Virginia is higher than the average, since the latest complete data available for the United States covers only the year 1957. The figures for that year show West Virginia with a maternal death rate of .37 as compared with the national average of .41.

### Other Death Statistics

Other death statistics for 1958 reported by Doctor Dyer show that three specific causes accounted for 63.5 per cent of the total, i. e., heart disease, with 6,602 deaths (37.4 per cent); cancer with 2,473 deaths (14 per cent); and vascular lesions affecting the central nervous system with 2,144 deaths (12.1 per cent).

### Accidental Deaths Ranked Fourth

Accidental deaths of all types ranked fourth, with a total of 1,182, a decrease of 162 from the number recorded in 1957.

### TB Not Among First Ten Causes of Death

It is interesting to note from Doctor Dyer's report that tuberculosis has dropped from the ten leading causes of death in West Virginia. A total of 164 deaths were reported for the year 1958, with a death rate of 8.3 per 100,000 persons. There were 166 deaths in 1957. Syphilis was listed as the cause of 45 deaths, poliomyelitis, 11 deaths, and measles, 12 deaths.

## Lay Epilepsy Societies Organize American Epilepsy Federation

The Owen Clinic Institute, Inc., of Huntington has announced the formation of the American Epilepsy Federation, the first organization of its kind in the Americas. The federation is composed of 26 lay epilepsy societies representing 13 states, and the Owen Clinic Institute is an affiliate.

It has been explained that the new national body was organized so that a "concerted and coordinated attack on the problems of the epileptic could be inaugurated." Membership in the federation is open to any lay epilepsy organization in the Americas, and assistance will be provided to individuals who desire to form a lay group.

Detailed information concerning the new federation may be obtained by writing the Epilepsy Division of the Owen Clinic Institute, Huntington, or the American Epilepsy Federation, 77 Reservoir Road, Quincy 70, Massachusetts.

## New Executive Director Named By W. Va. Heart Assn.

Frederick S. Kelley of Hartford, Connecticut, has been appointed executive director of the West Virginia Heart Association. He assumed his duties last month following announcement of his appointment by Dr. J. J. Jenkins, Jr., of Fairmont, the president.

He succeeds Mrs. Caroline R. Rainbolt of Charleston, who has been serving as executive secretary. She will continue on the staff as program director.

Mr. Kelley is a native of Wilmington, Delaware, and has served as executive director of the Greater Hartford (Connecticut) Tuberculosis and Health Society for the past ten years.

He was graduated from the University of Delaware, attended Temple University School of Medicine, worked as assistant biochemist with Merck Sharp and Dohme of Philadelphia, and was administrator and laboratory supervisor in the Army Medical Corps.

## Public Health Association To Meet In Bluefield, May 12-13

The 36th Annual Meeting of the West Virginia Public Health Association will be held at the West Virginia Hotel in Bluefield, May 12-13. The theme will be "Meeting New Responsibilities in Public Health."

An interesting and impressive program is being arranged by the chairman, Dr. N. Allen Dyer, Health Officer of the Mercer-Bluefield Health Department. The theme will be developed by outstanding leaders in the various public health disciplines.

Full information concerning the meeting will appear in future issues of *The Journal.*

The essence of courage is not that your heart should not quake, but that nobody else shall know that it does.—E. F. Benson.

# 93RD ANNUAL MEETING

of the

# *West Virginia State Medical Association*

## *The Greenbrier*

AUGUST 25-27, 1960

## Chapel at WVU Medical Center Gift of C. E. Silling

An All-Faiths Chapel, a gift from C. E. Silling of Charleston, will be located on the first floor of the new Teaching Hospital at the West Virginia University Medical Center.

Mr. Silling, architect for the Medical Center, presented the Chapel to the University in memory of his mother, Rebecca Virginia Rust Silling. The Chapel, when completed, will be open day and night to persons of all faiths.

There will be approximately 30 seats of wrought iron finished in gold, a gold-colored rug, a communion rail

**The finished wood relief for the All-Faiths Chapel which will be located in the Teaching Hospital at the West Virginia University Medical Center. Milton Horn of Chicago was the sculptor. (Photo by Estelle Horn).**

of wrought iron, and other furnishings in keeping with the deeply religious all-faiths purpose of the chapel.

Preliminary plans for the Chapel were begun in 1957 by Mr. Silling. in collaboration with Milton Horn, prominent sculptor of Chicago, who executed the Georgia marble pylons at the entrance to the Basic Sciences Building.

For the Chapel, Mr. Horn designed and carved an arkreredos wood relief which stands 11 feet high and is 7 feet wide. He carved the relief from wood from the limba tree which grows only in Africa and which was selected since it does not change shades as it ages.

A native of Russia, Mr. Horn is regarded as one of the most versatile artists in the field of sculpture. He works in stone, marble, wood, metal, terra cotta, aluminum and many other available media. He served as Professor of Art and Chairman of the Department at Olivet College, Olivet. Michigan, 1940-49.

## Blue Shield Developing Special Programs for the Aged

A recent report released by the National Association of Blue Shield Plans indicates that a vast majority of the Blue Shield Plans in the United States have developed special programs for the aged.

John W. Castellucci, executive vice president of the Association, stated that the nationwide Blue Shield Plans and their sponsoring medical societies have registered outstanding progress in implementing the American Medical Association resolution, passed at the Clinical Meeting held at Minneapolis in December, 1958, calling for the development of medical care coverage for the aged by voluntary means.

A recent survey indicated that "only eight of the 67 Blue Shield Plans located in the United States, with only two per cent of the total Blue Shield membership, have no programs for senior citizens in the works at the present time."

Mr. Castellucci said that the remaining 59 Plans either have special aged programs already being offered in their areas, or have programs in various stages of development.

## Dr. John Paul North Named Director Of American College of Surgeons

Dr. John Paul North of Dallas, Texas, the new director of the American College of Surgeons, will assume his duties at the headquarters offices in Chicago on January 1, 1961. He will succeed Dr. Paul R. Hawley who has served as director since March, 1950.

Doctor North has been chief of surgical service at the VA Hospital in Dallas since 1955 and has served as professor of clinical surgery at Southwestern Medical School of the University of Texas since 1946. He has been a Fellow of the ACS since 1935 and a member of the Board of Governors since 1954.

He is widely known for his contributions in the field of trauma and has served with distinction on the College's Committee on Trauma which has as its objective improving the transportation and care of the injured. He now represents the ACS on the President's Committee for Traffic Safety, and is chairman of the College's Subcommittee on Traffic Safety.

### Depression Defined

By definition a depression is a constellation of complaints or symptoms having as the dominant theme a discouraged, pessimistic outlook on life. Depression may occur in many different psychiatric conditions, or in conjunction with various physical diseases and is, therefore, not diagnostic of any particular syndrome. The importance of recognizing and dealing with depression cannot be overemphasized because each depressed patient is a potential suicide.—Charles E. Goshen, M. D., in New York State Journal of Medicine.

The West Virginia Medical Journal

March, 1960 Vol. 56, No. 3

# Management of Acute Cholecystitis—Cholecystectomy or Cholecystostomy?*†

*Stanley O. Hoerr, M. D., F. A. C. S.*

In the vast majority of cases, acute cholecystitis is a direct result of the mechanical action of gallstones. Most attacks of cholecystitis are brought about by the lodging of a stone in the cystic duct, thus preventing proper emptying of the gallbladder; more rarely, the erosive action of the stone on the wall of the gallbladder produces the attack. Since the distinction between gallstone colic and acute cholecystitis is a hazy one, in my own practice I assume that any symptoms of gallstone colic which have persisted for more than four or five hours are due to acute cholecystitis until proved otherwise.

Since the cause of acute cholecystitis is almost always mechanical, the logical treatment is correction of the mechanical factors. This means, in most cases, that cholecystectomy should be performed promptly, but in special circumstances cholecystostomy, with removal of the stones and drainage of the gallbladder, may be the wiser course. During the first two or three days of an attack, bacterial infection is rare; it is not rational, therefore, to treat the patient with antibiotics except as adjuvants to surgical therapy.

### Emergency Operation

It is rarely necessary to perform a surgical procedure for acute cholecystitis as a dire emergency, within an hour or two of the time the patient is seen, although in some cases the clinical condition will appreciably worsen in the course of a few hours under observation in the hospital. In such instances, emergency operation must be resorted to, and if circumstances make it appear wise to perform a cholecystostomy, the surgeon should not hesitate to do so and to be content with that procedure.

*The Author.*

- **Stanley O. Hoerr, M. D., F. A. C. S., Staff Surgeon and Chairman of the Division of Surgery, The Cleveland Clinic Foundation, Cleveland, Ohio.**

### 'Early' Operation

It is our usual practice to schedule operation for the day following admission, when a regular operative team is available and when it will be easier to obtain operative cholangiograms. This "early" type of operation is performed only when the diagnosis of acute cholecystitis is relatively certain. In many instances the patient will know that he has had gallstones and they will have been demonstrated on roentgenograms. If such proof of gallstones is lacking, a plain film of the abdomen may reveal stones, as 10 per cent of gallstones contain sufficient calcium to cast a shadow. Should the plain film reveal no stones, and if the patient is not too ill, it is my custom to give a double dose of Telepaque or Priodax on the evening of admission to the hospital (provided the patient is able to retain the pills). Roentgenograms taken the following morning will indicate the status of gallbladder function and the presence or absence of stones. These roentgenograms are then reviewed preoperatively, and if a normal gallbladder should be shown (as occasionally happens) operation is canceled and the search for the correct diagnosis continued. Diseases that may mimic acute cholecy-

*From an address presented before the Seventh Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice, at Charleston, W. Va., June 21, 1959.

†From the Department of General Surgery, The Cleveland Clinic Foundation and The Frank E. Bunts Educational Institute, Cleveland, Ohio.

Submitted to the Publication Committee, November 2, 1959.

stitis are acute hepatitis (with distention of the hepatic capsule as the presumptive cause of the pain) and occasionally disease of the right kidney. In my own practice, several patients who appeared to be suffering from acute cholecystitis proved to have normal cholecystograms!

### Indications for Cholecystostomy

On what type of patient should cholecystostomy be performed? Cholecystostomy should be performed on any patient who, in the opinion of the surgeon, cannot undergo a more extensive procedure because of the great operative risk. An elderly patient with a tense, tender, distended gallbladder, who has, in addition, such degenerative disease as severe arteriosclerotic heart disease, is wisely subjected only to cholecystostomy under local anesthesia. The surgeon usually can determine by the point of maximal tenderness where the gallbladder is likely to be located and, under local anesthesia, place a short incision (usually subcostal) directly over it. The gallbladder is opened, evacuated, as many stones as possible removed, and then an ordinary Foley catheter may be sutured into the gallbladder and brought out either through the incision or a small stab wound. It is not necessary to bring the gallbladder to the anterior peritoneal surface.

A second type of patient in whom cholecystostomy should be done is the patient with inflammation so intense or with old scarring so obscuring the operative field that the possibility of accidental injury of the common bile duct or the hepatic artery is greatly increased.

The surgeon must assume that stones will reform in the retained gallbladder following cholecystostomy, provided the patient lives long enough. It is our practice, in good-risk patients, to perform cholecystectomy as a second-stage procedure, in from two to six months after the cholecystostomy. In some elderly patients who are poor risks, the cholecystectomy may be postponed indefinitely; indeed, if there should be a second attack of acute cholecystitis, a second cholecystostomy may be performed.

### Representative Cases

The suggested management of specific patients as they might be seen in general practice may be helpful.

*Case I.*—You are called to the home of a 55-year-old businessman who is seized with an attack of acute cholecystitis at about 10 P. M. Roentgenograms in the past have shown gallstones. He has a business trip to New York planned for the following day and is loathe to cancel it. The attack has been in progress for several hours. There is tenderness in the right upper quadrant, and there is percussion tenderness over the ribs on the right side (a most reliable physical sign in acute cholecystitis). What do you advise?

I would regard it as good practice to administer at once an adequate dose of narcotic. (Morphine gr. ¼ and atropine gr. 1/150 would suffice in the average-sized patient otherwise in good health. Although morphine increases spasm of the bile ducts it also is the most effective pain reliever that we have, and the spasmodic effect can be offset by atropine). If the pain subsides promptly after the hypodermic injection (as it usually does), I think this patient may be sent on his way to New York mindful of the calculated risk of recurrence of the attack. Then, cholecystectomy should be planned for some future date when the timing is more convenient.

*Case II.*—The patient is a 45-year-old woman who has had pain for some six or eight hours, and when she is examined by you in her home you find tenderness present in the right upper quadrant and you believe that there may be an underlying intra-abdominal mass. No previous studies have been made. What should you do?

I would recommend administering a narcotic sufficient to control the pain, and arranging for her immediate admission to the hospital. A roentgenogram of the abdomen and chest should be made and may show calcified gallstones. If there are calcified gallstones you may be sure that they are the cause of the difficulty and an operation may be planned for the following day. If gallstones are not demonstrated by the roentgenogram, cholecystectomy may be planned tentatively for late the following morning. That afternoon and evening give a double dose of Priodax or Telepaque and give the gallbladder area a roentgen examination in the morning prior to the contemplated operation. If stones are demonstrated or if the gallbladder is not visualized, you may proceed with the operation, confident that the gallbladder is at fault.

*Case III.* (Based on a case in my own files.)—The patient, an enormously obese woman, in the mid-sixth decade, with residual hemiplegia from a stroke some months before, and the victim of two previous heart attacks, was a diabetic requiring roughly 100 units of insulin per day. The signs and symptoms of acute cholecystitis developed, including the presence of a tender mass that could be felt somewhere beneath the rolling fat of the massive abdominal wall. It was known that she had gallstones. How should she be treated?

Of course every effort was made to avoid operating on this patient because she was such a

dangerous surgical risk; when, however, after our observation of her for a number of hours, the pain persisted and ultimately localized, she was taken to the operating room and under local anesthesia underwent cholecystostomy. Prompt clinical improvement resulted, and the catheter was left in the gallbladder. In this particular case, we removed the catheter on the tenth postoperative day and the fistula promptly closed. The patient ultimately was discharged from the hospital. Further difficulty may develop but, if so, another cholecystostomy would be all that I should contemplate, the risk of elective cholecystectomy in this patient being far too great.

*Case IV.*—A man, aged 85 years, is seen at his home. He has severe abdominal pain, first beginning 24 to 48 hours previously. The pain has settled in the right upper quadrant of the abdomen. He does not seem to be extremely ill, but he is in pain. You have never examined him before. What should you do?

You may administer a narcotic, have him admitted to the hospital as an emergency, and carry out complete diagnostic studies. Cancer of the hepatic flexure has been known to imitate acute cholecystitis, and even hepatic metastasis may degenerate or have hemorrhage into the area, producing a picture clinically consistent with acute cholecystitis. Emergency operation would be performed only for increasing tenderness and pain or the clinical deterioration of the patient. The planned operation would be cholecystostomy under local anesthesia.

### Summary

Acute cholecystitis almost invariably is a result of the action of gallstones, and results initially in an inflammatory reaction that is nonbacterial. Infection is almost always secondary and follows after one or more days of pain. The ideal treatment is prompt cholecystectomy, but before cholecystectomy is performed the surgeon must be reasonably certain that the gallbladder is diseased. His certainty may stem from previous or current roentgen studies demonstrating either stones or nonfilling of the gallbladder, or from signs and symptoms of local inflammation sufficiently compelling to render further diagnostic studies unnecessary. The surgeon should never hesitate to perform cholecystostomy rather than cholecystectomy, either as a planned procedure in the very ill patient, or as a safety measure determined at the time of operation in the healthy patient who presents a difficult technical problem rendering cholecystectomy hazardous.

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# Pathology's Expanding Boundaries

PATHOLOGY has always occupied an intermediate position in the curriculum of the medical student, following anatomy and physiology and preceding medicine and surgery. That is obviously its natural position, but in many medical schools there has been a tendency in recent years to begin the study of pathology earlier and to continue it later.

If the study of pathology is extended in this way the main emphasis in the earlier part of the course will naturally be on general and experimental pathology, thereby laying a foundation for subsequent study of the aetiology and pathogenesis of disease.

When a proper grounding in basic pathological principles has been achieved the senior student will be better prepared for the study of special pathology as it is met with in the post-mortem room and at clinical conferences. Taught in this way pathology ceases to be an isolated discipline: it forms part of a continuous course which is closely integrated with microbiology, radiobiology, and immunology on the one hand and with clinical medicine and surgery on the other.—British Medical Journal.

# Pneumatosis Cystoides Intestinalis*

## (Case Report)

*John C. Condry, M. D., Robert E. Baer, M. D., and Benjamin Newman, M. D.*

The authors recently encountered their first case of pneumatosis cystoides intestinalis (gas cysts), and because of the rare occurrence of the disease feel that a published report is indicated. According to the literature, only a few more than 250 cases have been reported to date.

Pneumatosis cystoides intestinalis is said to have been known to John Hunter, in the eighteenth century, but the first adequate description of the disease was contributed by Bang, in 1876. Finney, in 1908, published the first report of a case in this country. It was not until the present decade, however, that we were furnished with a rather complete description of the disease, by Koss, who published his observations in 1952. The disease is not limited to man, having been found in animals as well. (Hobbs)

### Case Report

A 68-year-old white male, a physician by profession, was admitted to the Kanawha Valley Memorial Hospital on April 12, 1959, as an emergency case, with the provisional diagnosis of intestinal obstruction.

The patient had been troubled by constipation for several years and, more recently, by alternating bouts of constipation and diarrhea. The stools often contained mucus. There was no history of rectal bleeding. Eight months prior to admission, his physical status had been thoroughly investigated from the medical standpoint at one of the country's major clinics after he had experienced a cerebral accident. Studies of the gastrointestinal tract on that occasion were considered negative. Since then, however, he had had increasingly severe abdominal discomfort.

On physical examination at the time of the present admission, the abdomen was immoderately distended and there was a questionable mass in the left flank. Peristaltic sounds were increased.

A flat plate of the abdomen (Figure 1) revealed gas throughout the entire length of both the small and large bowel: findings consistent either with ileus or partial mechanical obstruction in the mid-sigmoid area. Also noted were a number of small negative shadows in the bowel suggestive of air-filled diverticula. Diverticulitis, therefore, was considered a possible cause of the partial obstruction.

At sigmoidoscopy the following morning, a smooth-surfaced, submucosal "mass" was encountered at a point approximately 20 cm. from

Figure 1. Flat plate of abdomen showing negative shadows consistent with air-filled pockets.

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Submitted to the Publication Committee, September 15, 1959.

the anal sphincter. On removing a specimen of the mass for biopsy purposes, a distinct "pop" was heard by the operator. Although not interpreted at the time, in retrospect it became apparent that one of the gas-filled cysts had been punctured by the jaws of the biopsy instrument.

On pathologic examination, the specimen was reported as "a fragment of large intestine with nonspecific subacute inflammation."

Barium studies (Figures 2 and 3) revealed partial obstruction in the mid-sigmoid area. Only traces of the barium were noted as having passed beyond a point 18 cm. from the rectal sphincter. Here the defect was extremely smooth, suggesting extrinsic pressure or an intramural mass.

On conservative treatment, the patient's condition improved symptomatically and he was prepared for surgery.

At operation, April 15, 1959, there was found an extremely large, redundant sigmoid colon containing an enormous number of intramural cysts which involved the whole sigmoid. The greatly dilated bowel was filled with hard fecal matter extending well down toward the area of the cecum.

Treatment consisted of resection of the involved length of bowel followed by end-to-end anastomosis.

The patient was discharged from the hospital in excellent condition on the 10th day after surgery.

### Pathology Report

"Gross Description: The specimen consists of 50 cm. of large intestine with some attached mesocolon. On the serosal surface there are numerous protuberances which are sessile or pedunculated and which are gas cysts. They measure up to 4 cm. in diameter (Figure 4). The cysts for the most part are multilocular and on section appear to involve the subserosa and submucosa. From the mucosal surface the cysts appear polypoid and grape-like (Figure 5). The lumen of the bowel is narrowed throughout. The proximal and distal ends of the specimen for a length of 5 cm. are not involved. The pericolic lymph nodes measure up to 0.5 cm. in diameter and are pink-tan and soft.

"Microscopic Description: The mucosa shows no histopathologic changes. The submucosa contains large empty spaces which are lined by endothelial cells (Figure 6). Other areas show the lining cells to be multinucleated. The subserosa contains similar cysts. The pericolic lymph nodes contain dilated lymphatics and show some histocytosis (Figure 7).

"Diagnosis: Pneumatosis cystoides intestinalis."

### Discussion

Gas cysts may form at any point in the gastrointestinal tract but the most common site appears to be the small intestine. The cystic spaces

Figures 2 and 3. Barium enema studies revealing partial obstruction and "smooth" defect.

usually are located in the submucosa or subserosa. Most observers feel that the gas resides in lymphatic spaces. The gas has been found to contain oxygen, nitrogen and carbon dioxide. Rupture of the cysts may occur and when in association with the subserosal cysts, give rise to pneumoperitoneum. Puncture of a cyst is accompanied by a distinct sound, the result, apparently, of sudden release of gas under pressure. One of us (J. C. C.) made this observation when removing the biopsy specimen at sigmoidoscopy, as related previously.

### Mechanism of Development

A number of theories are held regarding the mechanism of development of gas cysts, included among which are the hypothesis of bacterial influence, and the mechanical and dietary deficiency theories.

The bacterial theory postulates that the gas contained in the cyst is produced by bacteria

Figure 4. Gross appearance of gas cysts with smooth lining. Slightly magnified.

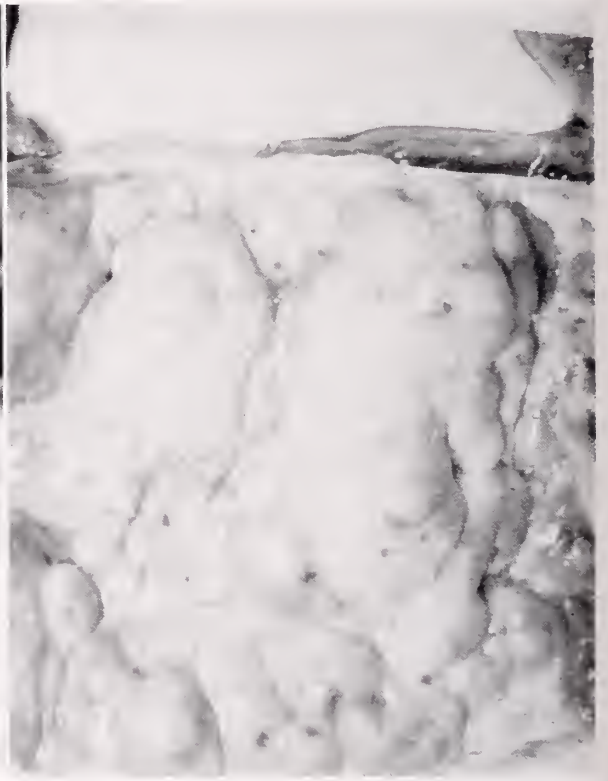

Figure 5. Mucosal surface of colon showing grape-like masses caused by formation of submucosal gas cysts.

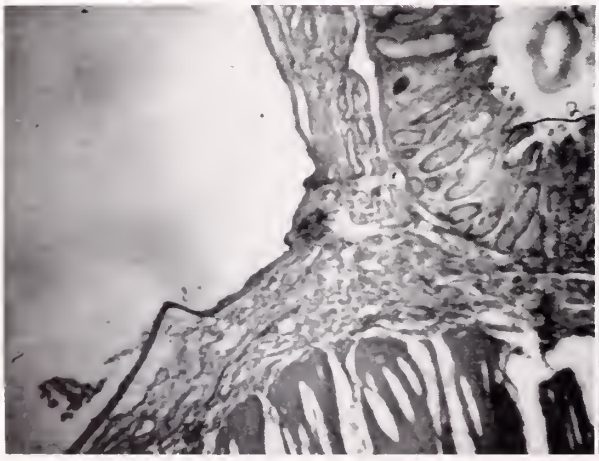

Figure 6. Submucosal cysts compressing mucosa and muscularis. (X 100).

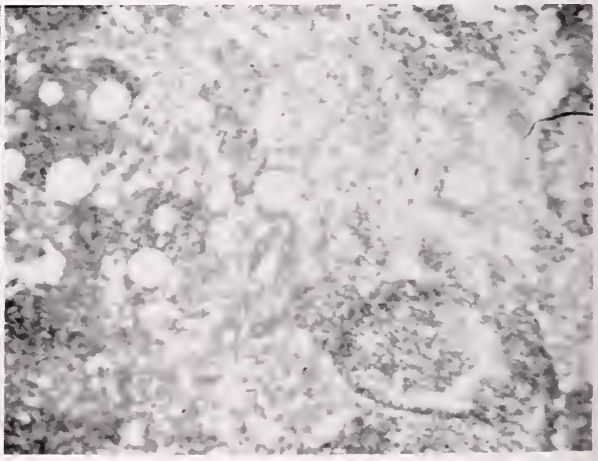

Figure 7. Lymph node with dilated lymphatics. (X 100)

within the lymphatics and tissues. Inasmuch as cultures, however, usually have been negative, there appears little in the way of substantial evidence to support the belief.

The mechanical theory implies that the intraluminal gas is forced into the lymphatics of the gastrointestinal tract through a mucosal defect.

The theory of dietary deficiency has been suggested as an explanation of those cases in which the mucosa is intact. (Kukral)

Pneumatosis cystoides intestinalis has been reported in association with a variety of gastrointestinal disorders such as peptic ulcer, intestinal tuberculosis, appendicitis, chronic enterocolitis, regional enteritis, and the like.

### Summary

Although known as early as the eighteenth century, pneumatosis cystoides intestinalis is a disease with an uncommonly low frequency rate. It occurs in animals as well as in man. Formation of the gas cysts appears to be most common in the small intestine although they may form at any point in the gastrointestinal tract.

A case of pneumatosis cystoides intestinals in which the left side of the colon was involved is presented. Surgical therapy consisted of resection of the diseased segment of colon and primary anastomosis, with an excellent result.

Pathologic examination of the resected length of bowel showed changes which, it is thought, lend support to the mechanical and the dietary deficiency theories regarding the etiology of gas cysts.

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# We Must Lead

Today we are in the midst of times characterized by intense, ceaseless struggles by individuals, groups, races and nations for positions of power and influence. In these struggles the ideals of medicine are involved, not as the primary issue, but secondarily in a program of socialized health and welfare.

Just what part medicine is to play in guiding its aspect of the program, and whether that part will be to the good or detriment of mankind, will depend upon whether we are motivated only by ego and desire for power or by a real wish to help. These programs should be guided so they will result in a minimal loss of the rights of the individual and the maximum use of the facilities of organized society and government.

Many people say that the movement toward guaranteed medical care and hospitalization for all citizens has gone so far that it will not be turned back. The problem facing us is how to prevent this movement from destroying the doctor-patient relationship, which is built on moral and spiritual values. How well we succeed will depend largely on our own behavior. We will go further by looking for our own errors and respecting our opponents' strengths.—Leslie E. Daugherty, M. D., in Maryland State Medical Journal.

# The Significance of Blood in the Urine*†

*Charles C. Higgins, M. D., F. A. C. S.*

Blood in the urine is one of the more frequent symptoms of disease of the genitourinary tract. Hematuria, the presence of blood in the urine, therefore, is not a clinical entity for which treatment is instituted but, rather, a symptom demanding and necessitating immediate, at times exhaustive, investigation to ascertain the underlying etiologic factor. It is well recognized that practically every disease of the urinary tract may at some time be responsible for the presence of blood in the urine. Of great significance is the fact that the profuseness of bleeding is not necessarily an index of the severity of the disease.

As a general rule, hematuria associated with inflammatory lesions of the urinary tract may be associated with coexisting symptoms such as dysuria, frequency, urgency and nocturia. In contrast to this observation, however, hematuria associated with potentially malignant or malignant lesions may be the only symptom, and concomitant symptoms may be strikingly absent.

When associated with pathologic lesions involving the urinary tract, hematuria frequently is intermittent in character. The bleeding usually subsides spontaneously only to recur later at varying intervals. During the periods when blood is not detected in the urine the gravity of the symptom may be minimized, procrastination countenanced and, when an accurate diagnosis is established, the golden opportunity for bringing about a cure has long since passed.

If we are to establish the diagnosis of a neoplasm early in the course of the disease, the public must be informed and impressed with the significance of blood in the urine, and must be advised to consult the physician promptly in order that the correct diagnosis may be made and appropriate treatment may be instituted.

### An Obsolete Term

A few words seem to me appropriate here, relative to the term, "essential hematuria," which was coined to denote a condition in which the etiologic factor eludes detection. The term implies an entity. For urologists to imply to medical colleagues the existence of such an entity is an action fraught with danger when incontrovertible proof of such a disease remains nebulous. Inability to detect the etiologic factor usually is due to "sins of omission" and to all of the procedures available in our diagnostic armamentarium not having been utilized to ascertain the source of bleeding in the patient.

As I stated[1] at the meeting of the International Congress of Urology, in Stockholm, in 1958, "It is time to pause, reflect, and to decide whether or not the so-called 'Entity' rests on unshakable foundations or should not be relegated to oblivion. It is still my firm conviction that 'essential hematuria' is obsolete terminology and should be entirely abandoned."

As I have repeatedly stressed, when a patient who has hematuria or a history of hematuria consults a physician, the physician assumes the obligation and the responsibility of proving beyond a question of a doubt that a serious organic lesion or a neoplasm is or is not present in the genitourinary tract. Procrastination cannot be condoned; immediate urologic survey is mandatory.

### Microscopic Hematuria

Frequently the question is asked, "What is the clinical significance of microscopic hematuria?" Larcom and Carter[2] reported their findings in regard to 3,000 consecutive voided urine specimens from young men applying for insurance. In this series, they found 2,484 specimens negative for erythrocytes. In 60 instances (approximately 2 per cent) the specimens contained 2 to 3 red blood cells per high-power field, but in 23 (0.7 per cent) there were 4 to 5 red blood cells per high-power field. They concluded, "These values support our findings on the correlation of quantitative studies that the repeated excretion of more than two red blood cells per high-power field may be significant." A carefully elicited history

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*From an address presented before the Seventh Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice, at Charleston, W. Va., June 20, 1959.

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Submitted to the Publication Committee, September 1, 1959.

followed by a careful examination cannot be overemphasized.

In women it is essential for the physician to determine whether the bleeding occurs only during urination or whether blood is detected aside from urination. When the spotting occurs independently of urination, the source of bleeding is the urethra or the vagina. Thus, pelvic examination is of utmost importance. When there is hematuria either in men or women, a rectal examination should be standard procedure; in women, obviously, the specimen of urine should be secured by catheterization.

In men, it is essential that one note the type of hematuria. In instances in which the hematuria is initial, blood is to be observed only at the beginning of urination, and during the act of voiding the urine becomes clear. Bleeding of this type can be presumed to originate in the anterior or prostatic urethra. If the bleeding is terminal, the urine is clear until the end of urination, at which time a few drops of blood may be observed. Lesions of the posterior urethra, less frequently lesions of the bladder neck, usually are the source of terminal hematuria. In complete hematuria, i. e., when the urine and the blood are well mixed, the origin of the bleeding usually is in the bladder, the ureters, or the kidneys.

Complete laboratory data, including special studies for blood dyscrasias, Addis determination, urea clearance and blood chemistry investigations may be required to establish the diagnosis.

### Classification

The following grouping[3] has been found useful in the classification of hematuria:

I. Hematuria associated with systemic diseases and general conditions

A. Acute fevers
   1. Scarlet fever
   2. Rheumatic fever
   3. Tonsillitis
   4. Measles

B. Chronic infections
   1. Endocarditis (renal infarction)
   2. Malaria

C. Blood dyscrasias
   1. Hemophilia
   2. Polycythemia vera
   3. Purpura hemorrhagica
   4. Leukemia
   5. Sickle cell anemia

D. Deficiency and dietary diseases
   1. Scurvy
   2. Liver deficiency
   3. High protein diet (?)

E. Illnesses following medication
   1. Urotropin (R)
   2. Cantharides
   3. Mandelic acid
   4. Sulfonamides
   5. Salicylates
   6. Barbiturates

F. Diseases of unknown etiology
   1. Hodgkin's disease
   2. Hypertension or arteriosclerosis with renal involvement
   3. Periarteritis nodosa
   4. Glomerulonephritis

II. Hematuria due to intrinsic disease of the genitourinary tract

A. Renal
   1. Calculi or crystals
   2. Nephritis
   3. Tumor (capsular, parenchymal, pelvic)
   4. Infection, acute or chronic, including tuberculosis
   5. Anomalies, polycystic kidneys, pelvic kidneys, horseshoe kidneys
   6. Trauma

B. Ureteral
   1. Calculi
   2. Infection
   3. Stricture
   4. Tumor

C. Vesical
   1. Tumor
   2. Infection
   3. Calculi or foreign bodies
   4. Ulcer
   5. Trauma

D. Bladder neck
   1. Hypertrophy of prostate, tumor, infection
   2. Infection of seminal vesicles

E. Urethra
   1. Infection
   2. Tumor
   3. Stricture
   4. Trauma

III. Hematuria associated with extraurinary pathology

A. Acute appendicitis
B. Diverticulitis of colon
C. Neoplasm of colon, rectum or pelvic structures
D. Acute and chronic salpingitis

The foregoing tabulation, although it does not include all of the etiologic factors instrumental in the production of red blood cells in the urine, serves as a working outline for each individual

case. It also indicates the intensive and comprehensive investigation that is at times required to determine the source and the cause of hematuria.

### Most Frequent Causative Factors by Age Groups

It is of interest to review the most frequent causative factor instrumental in the production of hematuria in the different age groups. From my review of our records at the Cleveland Clinic, the commonest causes of hematuria between the ages of one year and five years, in order of frequency, are: cystitis, pyelonephritis and glomerulonephritis. The common malignant tumor of the kidney in this age group, Wilms's tumor, sometimes is instrumental in the production of blood in the urine. In our series it was present in 18 per cent of patients. As a general rule, a mass palpable in the renal area usually is the first indication of the presence of the malignant growth; also, an unexplained elevation of temperature may be the only symptom. Neoplasms of the bladder are unusual in children. In male infants an ulceration of a stenosed urethral meatus is a frequent cause of bleeding.

In children between five and ten years of age, the most usual etiologic factors, in order of frequency, are glomerulonephritis, cystitis and pyelonephritis. In both sexes inflammatory lesions with cystitis and pyelonephritis are the most frequent causative factors from ages eleven to thirty years. Occasionally, calculous disease or a papilloma of the bladder is encountered.

The inflammatory lesions continue to predominate between the ages of thirty-one and forty years and, in men, the second and third most frequent causes are papilloma of the bladder and renal calculi, respectively. In women of this age group (31 to 40 years) inflammatory lesions of the urinary tract continue to be the principal etiologic factors, with calculous disease being next of frequency and, of least frequency, papilloma of the bladder.

In men between the ages of forty-one and fifty years a serious change in the causative factors is observed. Papilloma of the bladder and carcinoma are the principal offenders, followed by calculi and inflammatory lesions. Inflammatory lesions continue to have the major role in the production of blood in this age group in women, calculous disease and neoplasm of the bladder having minor roles. The neoplasms of the kidneys or the bladder are more frequently observed in patients more than forty years of age, but may occur in any age group.

In men between the ages of fifty-one and sixty years the cause of bleeding in descending order of frequency is neoplasm of the bladder, hypertrophy of the prostate gland, carcinoma of the prostate gland, and cystitis; whereas, in women of this age group, the same relative order of frequency is neoplasm of the bladder, and cystitis.

Finally, in men between the ages of sixty-one and seventy years, prostatism, benign or malignant, is the most frequent etiologic factor, then neoplasm of the bladder and inflammatory lesions. In women of these ages, neoplasm of the bladder and cystitis assume the major role in the production of hematuria.

From a review of these data it is evident that inflammatory lesions of the urinary tract are the most frequent initiating lesions of hematuria in patients less than forty years of age. It is well to realize, however, that inflammatory lesions and neoplasm of the bladder may coexist in the individual patient, and malignant or potentially malignant tumors may occur in any age group.

In the older age groups the presence of a malignant or potentially malignant tumor must be seriously considered as a cause of hematuria until ruled out by cystoscopic survey.

As Rathbun,[4] in 1933, stated: "If we could impress upon every man practicing medicine the fact that in 50 per cent of all cases, hematuria is produced by a tumor and that a large majority of these cases are malignant or potentially malignant, we would do more to reduce our cancer mortality and morbidity than can be done any other way."

### Conclusions

Hematuria is a symptom and not a clinical entity. Immediate investigation including cystoscopy is mandatory. Cessation of the bleeding and absence of other symptoms do not minimize the gravity of the condition. The public must become cognizant of the serious aspects of hematuria and must be advised to seek immediate medical counsel when it is first observed.

The physician assumes the obligation and responsibility of proving beyond doubt the presence or the absence of the neoplasm or other serious lesion in the genitourinary tract.

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# Surgical Problems in the Geriatric Patient*

*James E. Boggs, M. D., and Bert Bradford, Jr., M. D.*

In emergency or elective surgical conditions, a delay of a few hours or a few days often widens the margin of safety in the case of the geriatric patient. It gives the physician time to evaluate his condition with regard to the metabolic, cardiovascular, pulmonary and renal status and to make at least partial restoration of the deficits prior to surgery. The surgeon who feels that there is not a moment to lose with regard to the geriatric patient will have a high mortality rate. The mortality and morbidity rates of the older patient after surgery usually are due to physiological derangements present before surgery. The usual preoperative evaluation as to operative risk is by clinical impression based on history, physical examination and routine laboratory determinations. These measures alone are inadequate in the case of the geriatric patient, in which some degree of arteriosclerosis, pulmonary emphysema, and electrolyte derangement is likely to exist. Therefore, to determine the probability of development of an abnormal response to surgery, a very detailed history and physical examination plus certain additional laboratory studies are necessary. To achieve this, one must make a careful evaluation of the following factors: (1) cardiovascular status, (2) pulmonary status, (3) renal status, (4) adrenal status, (5) the pathology and physiology of the surgical disease in question and (6) the approximate magnitude and duration of trauma as concerned in the planned operation.


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### History

The history is of prime importance in evaluating the patient's condition prior to surgery. Loss of memory is frequent in the elderly patient and important information may be minimized or completely ignored. It is during the preoperative period that the success or failure of a surgical procedure often is established. There are certain questions frequently neglected in the patient's past history that are important in predicting the response to surgery. Special emphasis should be placed on the following questions when evaluating the condition of the geriatric patient:

What was the urinary output the past 24 hours? Oliguria and acute personality changes in the aged patient should suggest a metabolic abnormality. Frequently there is no record on the patient's chart of the urinary output before and after hospitalization. Only after inquiry is it discovered that he has not voided for 24 to 48 hours.

What is the mental status? Delirium of acute onset, hallucinations, and behavior deviations frequently are the earliest symptoms of water and electrolyte excesses. One should think immediately of a multiple electrolyte water depletion when there is a history of vomiting or diarrhea, rapid weight loss, oliguria, and mental changes.

What was the past nutritional state? Inquire carefully as to the number of meals eaten per day and, more important, how much of each meal is eaten, and the exact amount of weight loss. A body weight loss of 10 pounds represents a protein loss of 900 Gm. A gradual weight loss over a long period of time usually is due to a malignancy, whereas a rapid weight loss in a matter of hours represents body water loss. A rapid loss of three kilograms of body weight is equivalent to a loss of two liters of body water.

What is the cardiac and pulmonary reserve? There often are subclinical degenerative changes with impairment of the functional capacity of the cardiorespiratory systems which are not detected on routine history and physical examination. For example, a history of a productive cough during the morning, and during the evening on exposure to cold air, is suggestive both of emphysema and bronchiectasis. The operative mortality rate in patients with an anginal syndrome varies between 5 and 8 per cent, with an incidence rate for cardiorespiratory complications as high as 35 per cent.[1] Special emphasis, therefore, should be placed on the following: tachycardia, cyanosis, arrhythmias, dyspnea, orthopnea, chest pain and

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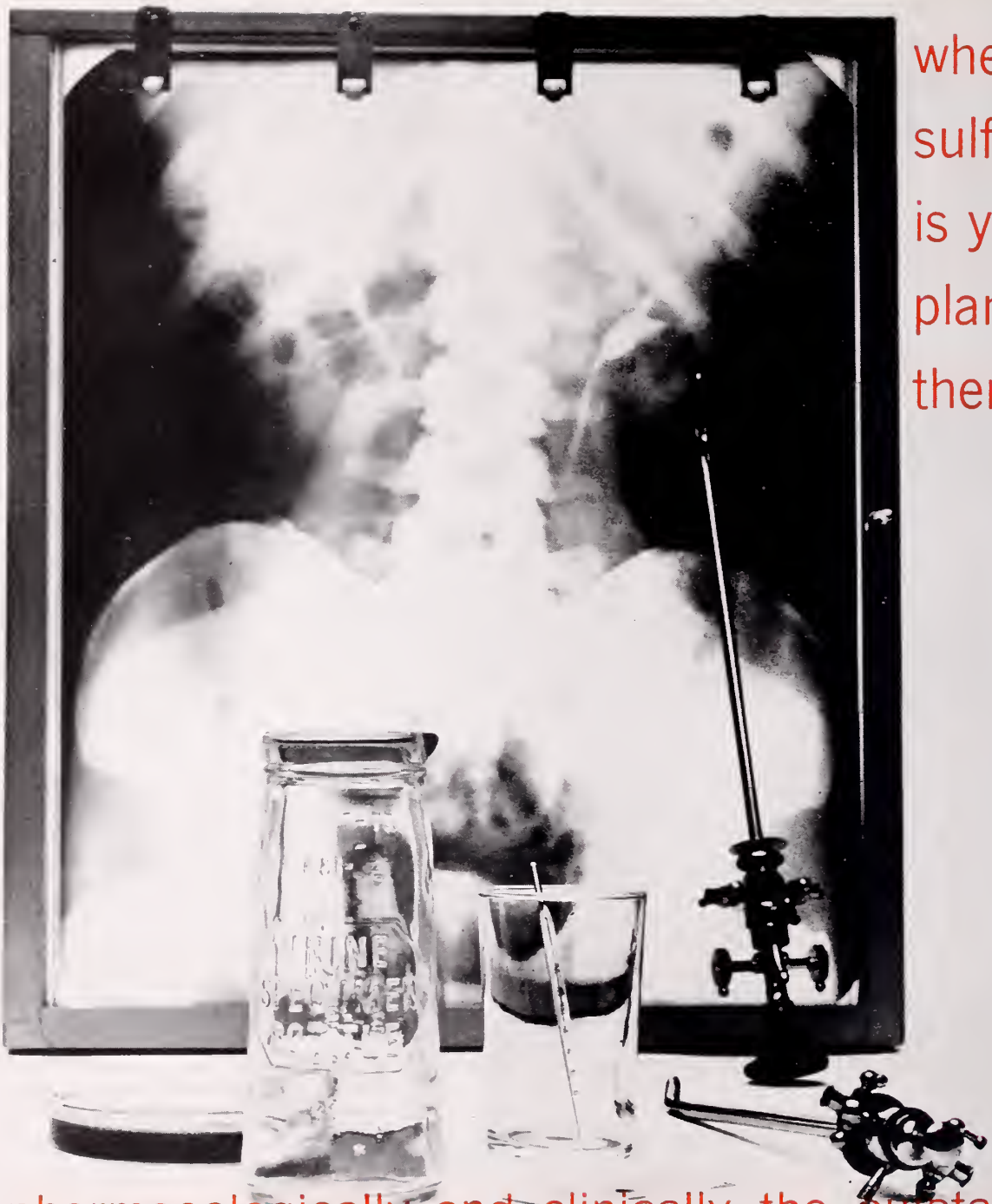
Submitted to the Publication Committee, September 18, 1955.



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edema. The functional capacity of the heart is based on the relation between symptoms and ordinary activity in the patient with cardiac disease.

Has there been previous steroid therapy? Any geriatric patient who has received therapeutic doses of cortisone in the nine month period preceding operation should have supplemental cortisone the day before, during, and in the immediate postoperative period.

Has the patient shown any type of allergic reaction to previously administered drugs? Any known drug sensitivity should be clearly marked on the patient's chart. Frequently a drug is administered during surgery or in the immediate postoperative period and it is discovered later that the patient is sensitive to it, after the damage has been done.

What was the response to previous surgery? A history of prolonged reaction time from anesthesia, as well as hypotension during previous operations is a clue to adrenal insufficiency.[2, 3]

### Physical Examination

Usually, special emphasis is placed on certain irreversible pathologic processes such as arteriosclerosis, hypertension, valvular heart disease and emphysema, and not on the reversible pathologic processes such as secondary anemia, diminished blood volume, dehydration and electrolyte derangement. Close observation of the following factors should forewarn the surgeon of the possibility of these reversible pathologic processes, as well as furnish a better evaluation with regard to the irreversible ones.

What is chronic shock? The syndrome is characterized by loss of weight, decrease in blood volume, decrease of the serum proteins, and an increased volume of interstitial fluid. The patient with chronic shock tolerates blood loss and sodium loss poorly.[4]

Is the patient adequately hydrated? Hydration is adequate when the buccal mucosa, axillae, and groin are moist. Dehydration is due to simple water loss or pure salt depletion, or both. Simple water loss is characterized by thirst, oliguria, and a rising nonprotein nitrogen. There is no disturbance in the circulation and the condition is quickly corrected by the administration of water. Pure salt depletion results in reduced volume both of plasma and interstitial fluid and is characterized by apathy, lassitude, fainting, and peripheral circulatory failure. Thirst is absent in salt depletion and the clinical condition is similar to shock that may result from other causes.

Reflexes—Decrease in deep tendon reflexes may be the first clue to potassium deficiency. Weakness of the hand grip should also suggest potassium deficiency.

Respiration—Fairly adequate clinical evaluation of the pulmonary reserve can be obtained by observing the chest during expansion, walking the patient up two or three flights of stairs, and observing the pulse pressure and rate of respiration. Observe the character and rate of respiration at rest because shallow, slow respiration is indicative of metabolic alkalosis. Deep and rapid respiration is indicative of metabolic acidosis. Patients with an obstructive type of lesion should receive bronchodilators, expectorants, intermittent positive pressure breathing and, in some cases, antibiotics before surgery.

### Selection of Laboratory Tests for the Geriatric Patient

Any patient for elective surgery should have certain base-line determinations which include a complete blood count and a complete urinalysis, with special attention to the specific gravity. All patients over 45 years of age should have an x-ray of the chest. A BUN or NPN determination is indicated in the cases of all geriatric patients, especially when albuminuria or hypertension is present.

The fractional PSP clearance is a simple, accurate and easily performed test for estimating renal function.[5] In screening a patient for an operation, a PSP excretion of 15 per cent or more in 15 minutes is adequate. No further tests such as NPN, BUN and urea clearance are necessary.

Any patient with a ventilatory defect should have base-line serum $CO_2$, and chloride and whole blood pH, as well as vital capacity studies and a roentgenogram of the chest.

There is very little correlation between the electrocardiogram and postoperative complications. The electrocardiogram is not a measure of the functional capacity of the heart. It may, however, be an early clue to, or show evidence of, many abnormalities of the heart, such as diffuse myocardial disease, hyperirritability, conduction defects, and myocardial infarction. In addition, a preoperative electrocardiogram provides a good base-line for comparison during the operation or in case of a cardiac complication or electrolyte disturbance after surgery.

The serum electrolytes, sodium, potassium, chloride and bicarbonate, in addition to the pH, serve as a base-line and detect electrolyte abnormalities before and after surgery. Many aged individuals will have hyponatremia without evidence of electrolyte loss. They have a narrow

margin of safety and minimal sodium loss is poorly tolerated.

The hematocrit is the best index of the effect of transfusion in patients who are anemic either from acute or chronic blood loss. A hematocrit drawn 24 hours after transfusion, when compared with the pre-transfusion hematocrit, will rise only one or two per cent points when the patient has deficient total blood volume. It will rise three or four per cent points after a 24-hour period when the deficit is only in red cell mass.

**Postoperative Period**

The most common circulatory problem encountered in the immediate postoperative period is hypotension. Cardiovascular and respiratory complications are the most common causes of hypotension in the geriatric patient. Certain drugs such as tranquilizers, opiates, and phenothiazine derivatives are a frequent cause of hypotension.[6] Tranquilizers and phenothiazine before surgery should be used with caution because these drugs depress significantly the body's ability to compensate for surgical stress, especially in the respiratory and circulatory system. Demerol also must be used with caution, especially in the patient with chronic pulmonary disease. Demerol frequently will produce shock in the patient with low blood pressure and a slow pulse. The geriatric patient often will have a reduced blood volume. Minimal blood loss will result in hypotension unless the low blood volume is corrected prior to surgery. The same patient frequently will have a low serum sodium or a loss of sodium in addition to the reduced blood volume. This condition plus the trauma of surgery, will result in hypotension. One should consider adrenal cortical insufficiency if the postoperative hypotension cannot be explained by these other causes. Blood should be drawn for a total circulating eosinophil count before treating the patient for adrenal cortical insufficiency.

The urinary output should be checked hourly for 48 to 72 hours after major surgery in the older patient and in all patients who are subject to extensive surgery. The 24-hour urine volume must be over 500 cc's. The 24-hour output of urine, however, cannot be relied on as a means of determining renal function. The urine volume is determined by the solute load and the ability of the tubule to reabsorb water.

Differential diagnosis between acute renal failure and dehydration and postoperative oliguria frequently is important. In dehydration or postoperative oliguria the urinary output seldom is less than 15 to 20 cc. per hour; the specific gravity usually is high, and albumin is absent unless present before surgery. There will be an increase in urine hourly volume with a provocative infusion and usually there is a fall in specific gravity. In acute renal failure the urinary output usually is much less than 15 cc. per hour, low in specific gravity (1.010 or less), and does not change in hourly volume or specific gravity with a provocative infusion. Total absence of urine output suggests a mechanical block and should be investigated on this basis. Postoperative oliguria is more striking in the aged patient than in the younger patient. The presence of oliguria the first and second days after surgery is a good sign provided the urinary output was adequate before surgery and the patient is hydrated. Excessive amounts of fluid should not be administered in an effort to increase the urinary output.

It is important to check on the reaction of the urine daily. Metabolic alkalosis with potassium and chloride loss, or tubular defects with sodium and potassium loss may be suspected if the reaction becomes alkaline. In extreme potassium deficiency, however, the urine may be acid in reaction because of an intracellular shift of hydrogen ions. A 24-hour urine specimen should be checked for total sodium content if renal tubular damage is suspected, with excessive sodium loss. Urine sodium content above 25 mEq. per liter immediately after surgery usually reflects adrenal cortical insufficiency or a "salt losing nephritis."

The most common postoperative complications are related to the respiratory system and carry serious implications for the feeble geriatric patient. Pre-existing pulmonary disease plus the loss of strength necessary for powerful coughing and ventilation already have reduced the respiratory reserve. The additional factors of anesthesia, narcotics, sedatives, prolonged bed rest, and postoperative pain may lead to retained secretions resulting in atelectasis, pneumonia, or respiratory acidosis.

The great importance of respiratory acidosis lies in the fact that it renders the patient more vulnerable to superimposed hemorrhage, hypotension, and cardiac arrhythmias. Stupor and coma eventually develop if the acidosis and hypoxia continue. The treatment consists of early ambulation, bronchodilators, expectorants, antibiotics for superimposed infection, and oxygen therapy. The patient with pulmonary and cardiac disease should be placed in an erect position as soon as possible after surgery because the supine position reduces the vital capacity approximately 10 per cent. Oxygen must be administered with caution to patients with severe pulmonary emphysema because the stimulus to respiration may be lack of oxygen. When this stimulus to respira-

tion is removed, breathing ceases, followed quickly by coma and severe respiratory acidosis. It is safest to give oxygen intermittently, 10-20 minutes at a time, lengthening the intervals between treatment periods as improvement occurs, when this type of situation is suspected.

Postoperative atelectasis and pneumonia are usually due to retention of secretions as a result either of impairment of ventilation or suppression of the cough reflex. In addition to pre-existing pulmonary disease, impairment of ventilation usually is increased by the supine position, tight and bulky dressings, and restricted motion of the abdominal muscles because of pain.

Cough reflex is decreased because of narcotics and voluntarily by the patient because of pain. Prevention consists of early ambulation, avoiding excessive use of narcotics and sedatives, intermittent positive pressure breathing with aerosols and bronchodilators, intravenous iodides, aminophyllin, and intratracheal suction.

All patients over 60 years of age probably should be treated postoperatively in the same manner as the patient with known coronary heart disease.[8] In this group there is a high postoperative incidence of thrombo-embolic disease, congestive heart failure, and recurrent myocardial infarction. The same measures for prevention of postoperative respiratory complications apply to the cardiovascular complications. Care should be exercised in the quantity and rate of infusion if fluids must be administered parenterally. Saline solutions should be given only when a specific sodium deficit exists. These patients tolerate anemia poorly; therefore, it should be corrected by multiple small transfusions.

It is important to remember that the normal response to surgery is characterized by intracompartmental fluid shifts, water retention accompanied by a retention of sodium and chloride ions, and a marked excess of loss of potassium and nitrogen. The increase of the extracellular fluid retention reaches its peak about the second or third postoperative day and amounts to 1000 to 2000 cc's. per day. This is the reason for administering no more than 1500 cc's. of salt-free fluids the first 24 to 48 hours after surgery, increasing the amount as the urine output increases. After the postoperative oliguria ceases, the ideal fluid is one low in sodium with normal potassium content. The duration of the oliguric period will depend on the magnitude of the operation and the presence of postoperative complications. There often is pre-existing renal damage in the geriatric patient and there will be less sodium retention after surgery. Hypotonic saline, therefore, may be indicated the first or second day after surgery.

The postoperative patient should receive at lease 100 Gm. of carbohydrate (glucose) daily to reduce protein catabolism. It has been shown that 100 Gm. of carbohydrate daily reduces protein catabolism by at least 50 per cent. Small doses of insulin added to the glucose solutions will increase the protein-sparing effect of glucose. Testosterone is a powerful protein anabolic agent and is helpful also in preventing postoperative protein breakdown. It is unnecessary to provide potassium for 36 to 48 hours after surgery if the aged patient is in good health before surgery. He should be given 36-50 mEq. of potassium daily if food intake is not possible at the end of this time.

Water intoxication is a type of hypotonic syndrome frequently observed in the older patient. It is more apt to be noticed in the first 24-48 hours after surgery. It is seen at this time because of the excessive administration of glucose in water or other hypotonic solutions.[10] The acute onset of a "neurologic or psychiatric" disturbance after surgery should bring to mind the possibility of acute water intoxication.[11] The diagnosis is made by the history of excessive water intake, central nervous system disturbances, and a gain in weight. The symptoms of water intoxication and sodium depletion are similar but in the latter there is loss of weight. The plasma sodium is low and may be as low as 105-115 mEq., whereas the plasma potassium is normal or slightly decreased. Treatment consists of restriction of water intake, and if cerebral symptoms are present, small amounts of hypertonic saline solution should be given.

True sodium depletion is more frequently observed in the older patient because of the increased incidence of renal tubular damage and chronic hyponatremia.[12] The onset may be rapid in the older patient, resulting in peripheral circulatory failure. The fact that weight loss has occurred is important in the diagnosis. The hematocrit and serum proteins are increased, and serum sodium and chloride concentrations are low. The potassium usually is increased. The urine volume is low and there frequently is a trace of albumin. One should consider the possibility of a "salt losing nephritis" when the sodium depletion is not because of extrarenal losses. A "salt losing nephritis" and adrenal cortical insufficiency should be considered when the level of urine sodium is above 25 mEq. per liter immediately after surgery. Treatment consists of administering sodium chloride solutions orally or intravenously, depending on the seriousness of

the situation. Hypertonic saline may be life-saving when the patient has severe sodium depletion.

### Summary

The patient who is unable to carry out a normal metabolic response to surgery often can be detected before surgery on the basis of a complete history, physical examination, and relatively few simple, properly interpreted laboratory tests. There is no substitute for careful bedside observation of the patient before and after surgery. An abnormal metabolic response to surgery will be reflected in certain symptoms and signs.

True sodium depletion, water intoxication, and asymptomatic hyponatremia are fairly common in surgery. Differentiation is relatively easy. Treatment is directed at the overall problem and not at the serum sodium concentration.

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# Rebirth of a Specialty

In the winter months the patient load of the general practitioner and the pediatrician may be as high as 50 per cent for upper respiratory complaints. They must rely on the erroneous impression that a working knowledge of antibiotic therapy eliminates the necessity for special training in this field.

The present day teaching in some institutions discourages or even forbids myringotomy in acute otitis media since there is no opportunity to associate an irreversible conductive deafness with past history of ear infections. The vocabulary has been reduced to the point where the word "sinus" covers all ailments of the nose and "fungus" all sore ears. Of equal importance, the otologist continues to pick up the perceptive deafness due to the indescriminate use of ototoxic drugs such as streptomycin, dihydrostreptomycin, kanamycin, and neomycin. It is evident then that more time must be allocated to undergraduate as well as postgraduate teaching.

The predictable effect of the prophecies of doom was the swing of the pendulum to the extreme negative side for the younger men entering the specialty, but the swing back has been noticeable for the past two years. Trainees are not motivated by prospects of a life of ease but by the desire to occupy an important niche in the practice of medicine. The demand for otolaryngologists in all parts of the country far exceeds the supply. Income guarantees in some instances are fantastic. The young man may hang his shingle almost anywhere and soon have more work than his time permits.—Claude D. Winborn, M. D., in Texas State Journal of Medicine.

# Cholecystography with Orabilex

## (A New Cholecystographic Dye)

*Michael M. Klein, M. D., F. A. C. R.*

It is a long way since the first oral cholecystographic medium was introduced by Graham. During the succeeding years we had favorites, each an improvement over the earlier ones. Currently, most of us have been using Telepaque, but the previous favorite, Priodax, is not yet out of the picture. After the success of Telepaque many other oral gallbladder dyes were brought out but did not make the grade and so we have been rather doubtful whenever a new cholecystographic aid has been introduced.

Priodax and, later, Telepaque, became popular because of the lesser number of side-reactions, the denser opacification of the gallbladder and the lower incidence of failure. There was, however, one ever-present, disturbing feature, namely, a radiopaque dust-like substance in the bowel. This often proved to be very aggravating, especially when the higher-lying colon overlay the gallbladder area, and even more so when concentration of the dye in the biliary system was under par.

Recently, Orabilex, a new compound, was recommended for visualization of the gallbladder, and this report describes the experience we have had with it in the Radiology Department of a Veterans Administration Hospital.

Orabilex is the sodium salt of a tri-iodo compound containing 57 per cent iodine (Telepaque 68 per cent, Priodax 51.5 per cent). We were greatly pleased in our original trials with this latest-in-line of cholecystographic contrast media, so it was decided to conduct a controlled evaluation of the new compound.

Our clinical material consisted of 50 selected patients, 25 of whom never had had any symptoms referable to the gallbladder or G. I. tract *per se*. Twenty-five had variable complaints. Several of these had had previous gallbladder series and, in some cases, were known to have a nonvisualized gallbladder. Aside from the aforementioned 50 patients, Orabilex was used to repeat the examination in a few cases in which one or the other of the cholecystographic media had failed. In our select series, we tried to include mainly individuals weighing over 180 pounds and with an abdominal circumference of 38 inches or more, in males, and 30 inches or more, in females.

Submitted to the Publication Committee, July 23, 1959.

### *The Author*

- **Michael M. Klein, M. D., F. A. C. R., Chief of Radiology, Veterans Administration Hospital, Huntington, West Virginia.**

Until recently, we have been using Telepaque 6-8 tablets (0.5 Gm. each), depending on the size of the patient. In cases of nonvisualization we usually repeated the examination, using a double dose of Priodax, 6 tablets at 3 p. m. (0.75 Gm.), and 6 tablets at about 7 p. m. When using Orabilex we gave only 6 tablets, regardless of the size of the patient.

In each case we followed the same routine. The patient was instructed to eat a heavy, fat-rich breakfast the day before the examination in order to have the gallbladder emptied; at noon, he was to eat a regular lunch, and in the evening a light and fat-free meal. Milk and ice cream were precluded. He was permitted to have water, tea, fruit juices and plain salted crackers until midnight. The 6 capsules were taken at 9 p. m., at 5-minute intervals, with small amounts of water. The examination was carried out 12 hours later.

Several factors caught our interest:

(1). The unusually low number of side reactions.

| | |
|---|---|
| None | 40 or 80% |
| Nausea | 5 or 10%* |
| Vomiting | 0 or 0% |
| Diarrhea | 0 or 0% |
| Heartburn | 1 or 2% |
| Itch | 2 or 4% |
| Rash | 2 or 4%** |
| Headache | 1 or 2% |

*One patient, reported as having had no side-reaction when interviewed at the time of examination, experienced slight nausea about 12 hours after the examination. Six days later, in

the same case, there developed a general scarlet fever-like rash.

**An additional case of nausea and rash, occurring approximately 24 hours following examination, was reported.

In the first instance, the rash disappeared in approximately 48 hours, without treatment. In the second instance, it was controlled in a few hours following antihistamine therapy.

(2). In all 50 cases we found visualization, and the percentage of very good and good visualization was unexpectedly high.

| | | |
|---|---|---|
| Very good | 25 | 50% |
| Good | 20 | 40% |
| Fair | 3 | 6% |
| Poor | 2 | 4% |
| None | 0 | 0% |

Of course, one must realize that the degree of visualization, i. e., good, fair or poor, depends upon the particular radiologist who reads the films. The dye-filled gallbladder may seem concentrating well to one radiologist but only fairly so to another. To judge the degree of concentration exactly would be a hard and a complicated task. We have to point out one fact: we did not have a single nonvisualizing gallbladder in our study. I emphasize here again the importance of preparation. The fatty breakfast 24 hours before examination is doing the trick. The ingestion of fat causes the gallbladder to empty all the sometimes thick, inspissated bile and so become more able to concentrate the dye.

We did a few cases of comparison. No visualization was registered without the fatty breakfast preparation.

The third thing noted was the good visualization of the gallbladder in patients weighing over 200 pounds.

The weight distribution and visualization are shown in the following table:

| | | Very Good | Good | Fair | Poor |
|---|---|---|---|---|---|
| 100-119 | 2 or 4% | 2 or 4% | | | |
| 120-139 | 7 or 14% | 7 or 14% | | | |
| 140-159 | 8 or 16% | 7 or 14% | 1 or 2% | | |
| 160-179 | 5 or 10% | 5 or 10% | | | |
| 180-199 | 7 or 14% | 3 or 6% | 2 or 4% | 1 or 2% | 1 or 2% |
| 200-219 | 11 or 22% | 2 or 4% | 7 or 14% | 2 or 4% | |
| 220-239 | 6 or 12% | 1 or 2% | 4 or 8% | 1 or 2% | |
| 240-over | 4 or 8% | 0 - 0 | 2 or 4% | 1 or 2% | 1 or 2% |

The most important finding in our comparatively small series was the almost complete absence of radiopaque residual in the bowel, which is a constantly disturbing and sometimes confusing finding after ingestion of all other cholecystographic media. In all 50 cases there were only 3, or 6 per cent, with opaque material in the large bowel after Orabilex; furthermore, these opacities were minimal in quantity, more discrete, and better distributed than one usually sees, and did not interfere with the interpretation of gallbladder pathology.

I cannot pass over another observation, namely, that after the fatty meal or other gallbladder stimulant (we use Neocholex—Bell & Craig), visualization of the cystic and common ducts occurred in a much higher per cent of cases, using Orabilex, than was true when the other cholecystographic media were used.

### Summary


1. A new cholecystographic contrast medium was tried in 50 cases.

2. Orabilex was given in a dose of 6 capsules (0.75 Gm. each) to all patients, regardless of weight.

3. Good visualization was obtained in 90 per cent of cases.

4. A low incidence of side-reactions was noted.

5. Almost complete absence of disturbing residual contrast material was observed in the bowel.

6. Good duct visualization and a high index of reliability in duct visualization were recognized.

7. Good or fair visualization of the gallbladder, noted in several cases in which repeated nonvisualization had been reported previously, points to the superiority of Orabilex.


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*. . . the years teach much which days never knew.*

Ralph Waldo Emerson.

# The President's Page

## Freedom of Choice

"FREE choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patient and physician"—"Actually no person can have an absolutely free choice for many reasons and if his freedom of choice is not absolute then it is not free but limited"—"A physician is free to choose whom he will serve."

The above are quotes from the Opinions and Reports of the Judicial Council of the American Medical Association as of November 1957. Since that date much has been written and more has been said that could not be put into print. So it goes with the controversies of individual physicians and societies with the various medical care plans.

I have chosen this subject not because it has been controversial, but to keep our membership informed. I expect this and similar subjects ever to confront us. It is my opinion that more attention must be given by individual physicians to such socio-economic aspects of medical practice as quality, cost and availability of medical care, medical legislation and medical education. Then and only then, through an informed group, can we ably and effectively discuss such controversial issues as Freedom of Choice with the various medical care plans whether they be union, industrial or governmental; call them third parties or what you will—let's keep informed.

Many of us have become so involved in the every day routine of patient care, hospital responsibilities and paper work that we have failed to see what is happening to the private practice of medicine. Changes are taking place and changes are bound to come about in spite of those who prefer the "good old days" to 1960. Since these changes are taking place, it behooves each of us, as individual practitioners, to guide this evolution in such a manner that our patients not only will have freedom of choice but the best quality of medical care at a price they can afford to pay.

Our only encounter with Freedom of Choice in West Virginia has been with the United Mine Workers Welfare and Retirement Fund. They have stated repeatedly that their curtailment of the right of free choice stems directly from the necessity of preventing financial abuse by physicians of their program by way of over utilization and prolonged hospitalization, as well as unnecessary procedures.

Since October, 1957, the Fund Administration has continued to operate as a closed panel, dealing with individual physicians, and not medical societies. The patient has a limited choice of physicians and hospitals on his list, but is denied unrestricted free choice of physician. Individual physicians may decline to participate, resign if they are participants, apply for participation or if their names are deleted from the list ask for reinstatement. In this sense, there is a freedom to choose, but the choice is determined by the Administration of the Fund. To date, in West Virginia, there has been no question as to the legality or ethical conduct of those who participate in this program.

"Medical societies should exert more effective efforts to eliminate unnecessary and excessive use and abuse of medical care plan benefits by a small minority of physicians."—before they become overly concerned about the Freedom of Choice of Physician.

J. C. Huffman, M. D., President

# THE WEST VIRGINIA MEDICAL JOURNAL

*Official Organ of the West Virginia State Medical Association*

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.



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*Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.*

*Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.*


# EDITORIALS

## CENTRAL CANCER REGISTRY PROVING ITS WORTH

The West Virginia Central Cancer Registry is three years old, and before it has gone very far into its fourth year statisticians from the American Cancer Society, the West Virginia Cancer Society and the Public Health Service will be trying to obtain preliminary information concerning cancer in West Virginia. The voluntary reporting from hospitals is a definite indication of the interest and concern of physicians who see cancer patients in their daily practice. It is a demonstration of confidence in the State Department of Health and the West Virginia Division of the American Cancer Society, and wherever the registry is discussed West Virginia physicians and hospital administrators are commended for their part in making the registry possible.

Until very recently, the only definite information available concerning the magnitude of the cancer problem in West Virginia has been from the Bureau of Vital Statistics where the grim count of deaths is available for any given year, but nowhere has there been a record of cancer patients who have survived, the number of new cases diagnosed in a year, or the most common site and age.

For every person in the general population of the United States who has knowledge of at least one cancer cure among his immediate acquaintances there are four who know cancer only in terms of the death of a close relative or friend. This is one of the findings of a national survey of public opinion conducted by the American Cancer Society in 1956. The prevalence of this fatalistic attitude not only conceals the fact that many patients are being cured but also indicates a tendency to emphasize failures and minimize successes.

The effectiveness of cancer treatment is best measured by the end results (survival time) attained, and such results can be brought to light only through careful compilation of adequate clinical records covering diagnosis, treatment and follow-up of patients. Abstract forms for reporting to the Central Cancer Registry have been sent to all hospitals in sufficient number to maintain a copy for the hospital registry, so that records of patients treated in any hospital are available; however, for the registry to serve the purpose for which it is intended, an adequate system of follow-up must be established in conjunction with the hospital registry and transmitted regularly to complete the Central Cancer Registry records.

A Central Cancer Registry is a means of auditing the results of treatment by knowing the status of the patient at any given time, which can be accomplished only through the continued

interest of physicians in helping to keep follow-up data complete. Securing follow-up is the most difficult problem facing the registry at this time.

Although the volume of material thus far accumulated is not quantitatively spectacular, it is of such quality as to indicate the value and importance of concentrated and cooperative effort in dealing with the problem. From the review, perhaps, a brighter picture of those who live will replace the cold statistics of the deceased, but at least two or three more years must pass before a sufficient number of cases will be registered and enough time has passed to consider survival on a five-year basis, since only cases diagnosed after January 1, 1957 are included in the Central Cancer Registry.

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**ANOTHER POLITICAL MENACE**

The press has just carried a news item concerning a bill introduced in the U. S. Senate for "health coverage" of retirees under OASI. We have not seen a copy of the bill, but from what we have read in the press, the author of the bill, to paraphrase Shakespeare, would out-Forand Forand and would go much farther toward shackling medicine, and incidentally the whole free interprise system, than would be the case under the bill introduced by the gentleman from Rhode Island. Likewise, there would be a tax increase.

We hope that every doctor of medicine familiarizes himself with the provisions of both bills and lodges a protest with his representative in the Congress against the enactment of any such legislation.

The enemy is at the gate. To Arms!

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**NEED FOR STUDENT LOAN FUNDS**

One of the most pressing needs in medical education today is adequate loan funds for students. The high cost of living, the increased cost of books and materials and the ever mounting tuition fees are creating a financial hardship for the majority of students. There are, for example, a number of medical schools with a tuition fee of $1,000 or more per year. This means that many students have to pay at least $4,000 for tuition alone.

It is trite to say that soon only the children of wealthy parents will be able to afford the luxury of medical education. This principle is, of course, quite wrong, for medicine needs men and women who have superior ability; in fact, medicine should be in a position to attract men and women of the highest intellectual and moral quality regardless of their financial background.

The consensus of medical educators today is that the number of applicants to medical schools is decreasing. Also, there is reason to believe that top-ranking applicants are apt to go to those schools which have excellent scholarships to offer. Increasing numbers of outstanding young people are attracted to physics and engineering where the period of training is shorter and the financial rewards more immediately procurable.

Loan funds should be available so students could borrow money at a relatively low rate of interest, applicable after graduation. It would be expected that the interest and principal would be paid as rapidly as possible after the student has completed his medical work. Earning capacity develops rapidly after training is completed, so no real hardship would be involved. The loans then would become a revolving fund to be used to help other needy young men and women for the years that lie ahead.

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### You're An Old Timer . . . So What?

There are 14 million people past the age of 65 in our country today and this number is being increased by 400,000 each year. Having established the fact that the mental capacities of these people have not deteriorated, what are we going to do with this enormous reservoir of brain power?

Almost all of these oldsters have been retired from industry, universities, and the Armed Services, and most of them are at loose ends. While it is the function of the physician to keep them in good health, our duty, it seems to me, goes beyond that. Good health itself, while tremendously important, is not enough. These people must be shown how to live happy and useful lives. This means that teamwork among physicians, psychologists, and the social workers must produce the answer to this tremendous problem. Some definite action needs to be taken since the problem will definitely not solve itself.

We need more basic research directed toward an understanding of the physiology of the aging process. We need also to establish Geriatric Evaluation Clinics in every general hospital supported by state, county, or municipal funds to take care of the immediate medical and psychologic needs of the oldsters. These clinics should be staffed by physicians, psychologists, and social workers. Through proper publicity and public relations, the old people in any given area served by a general hospital should be made aware of the service and facilities and they should be urged to take advantage of the clinic.—Edward Henderson, M. D., in Southern Medical Journal.

# GENERAL NEWS

## Senate Acts on Executive Appointments On Last Day of Session

The 30-day session of the 54th Legislature adjourned sine die on Thursday evening, February 11, after passing the Budget Bill which was agreed to by a conference committee earlier that day.

The so-called Foreign Doctors Licensing Bill (S.B. 31) was defeated by a 19-12 vote in the Senate on February 4. Earlier that same day, the House version of the bill (H.B. 47) was tabled by the House Committee on the Judiciary.

The controversial measure evoked a storm of protest from the medical profession. The principal reason for opposition was the fact that the bill, if passed, would have shorn the Medical Licensing Board of its authority to screen foreign graduates seeking permission to practice in hospitals in West Virginia and would have deprived the Board of its power to check qualifications and provide supervision during the period of training of the graduates of foreign schools.

The bill was introduced in the Senate on January 28 and referred to the Committee on the Judiciary. The following morning, representatives of the State Medical Association, calling to try to arrange a hearing, were told that the bill had been reported out favorably on the preceding afternoon, so no hearing was held by the Senate committee.

### Hearing Before House Committee

The companion bill (H.B. 47) was introduced in the House on January 29 and referred to the Committee on the Judiciary. The following morning the State Medical Association's request for a hearing was granted, and the hearing set for Wednesday, February 3.

At a meeting of the State Medical Association's legislative committee held in Charleston on January 31, the members voted unanimously to oppose the enactment of the bills, and representatives were named to appear before the hearing scheduled by the House Committee on the Judiciary.

The action of the House Committee in tabling the bill on February 4, as well as the Senate vote that same day to kill the measure, was reported to the entire membership of the State Medical Association in Legislative Bulletin No. 2, mailed on February 5.

The Senate debate found Senator Ward Wylie, surgeon of Mullens, and Senator Raymond Vassar, dentist of Weston, leading the fight to defeat the bill, while the debate for the passage of the bill was led by one of the sponsors, Senator Carl E. Gainer of Richwood, and Senator Joseph M. Handlan of Parkersburg. Full information concerning the matters brought out in debate was included in Legislative Bulletins Nos. 1 and 2.

### Senate Acts on Appointments by Governor

Shortly before adjournment, the Senate convened in Executive Session to consider the 72 nominations of persons for various state offices submitted by Governor Cecil H. Underwood. The list included the names of those appointed by the Governor since the Legislature adjourned in 1959.

With two exceptions, the Senate confirmed all of the nominations. Rejected were Richard J. Lilly, M. D., Director of the Department of Mental Health, and Hubert A. Kelly, Commissioner of Motor Vehicles. As of this date (February 18) the Governor has not filled these two vacancies.

Two physician-members of the Medical Licensing Board, Dr. William P. Bittinger of Summerlee, and Dr. Doff D. Daniel of Beckley, were renamed as members for the term ending June 30, 1964. Both have been members of the MLB since 1949.

P. R. Higginbotham, M. D., of Bluefield, was renamed a member of the State Board of Health for the term ending June 30, 1968, and Hu C. Myers, M. D., of Philippi, was reappointed as a member of the Advisory Board for the licensing of hospitals and related facilities, State Board of Health. His term will expire June 30, 1966.

The appointment of John D. Lee, M. D., as superintendent of the Andrew S. Rowan Memorial Home at Sweet Springs, was also confirmed by the Senate. He will serve at the will and pleasure of the Governor.

### 55th Legislature to Convene Jan. 11, 1961

The 55th Legislature will convene at the Capitol on January 11, 1961, for its regular sixty-day session.

## Yale Sesquicentennial

The Sesquicentennial of the Yale University School of Medicine will be celebrated at New Haven, Connecticut, October 28-29, 1960. One of the guest speakers will be Sir Howard Florey of Oxford, England, and the complete program will be released early in the summer by Dr. Herbert Thoms, a member of the committee arranging the celebration.

## Future Plans for 'U' Medical Center Revealed at Clarksburg Meeting

More than 220 persons attended a special observance of the 93rd anniversary of the founding of West Virginia University at the Stonewall Jackson Hotel in Clarksburg on February 4, sponsored by the Harrison County Medical Society. Dr. Richard V. Lynch, the president of the Society, presided.

Guest speakers at the dinner meeting included WVU President Elvis J. Stahr, Jr., Dr. Kenneth E. Penrod, Vice President of Medical Affairs at the University, and Dr. George F. Evans, immediate past president of the State Medical Association.

President Stahr, in a brief address, asked for the cooperation of state physicians in the development of the new WVU Medical Center at Morgantown. He said that it is imperative that we employ "long-range thinking" so that the Medical Center will serve the needs of tomorrow.

He said that citizens of this state now have the opportunity "of doing something really great" in developing one of the best schools of medicine in "the entire nation—the entire world" at Morgantown.

Doctor Penrod explained the aspirations, aims and some of the methods followed in setting up the clinical program at the Medical Center.

He emphasized that those persons charged with the responsibility of staffing the Medical Center are going to great lengths to obtain highly skilled and the best trained medical personnel possible.

Doctor Penrod discussed the facilities which will be available at the Center for practicing physicians in the state. He said that physicians will be able to refer difficult diagnostic cases to the teaching hospital where the patients will have the advantage of the best in clinical help, research and care.

Doctor Penrod also said that postgraduate courses will be offered for practicing physicians in all fields of medicine, but that only with the support and cooperation of physicians throughout the state can the Medical Center prove a success.

The guest speaker on the scientific program was Dr. T. Walley Williams, of the Department of Microscopic Anatomy at the Medical Center. His subject was "A New Concept and Approach to the Teaching of Sub-Macroscopic Anatomy." He also discussed future teaching principles and demonstrated some of the preparations made at the medical center.

Doctor Evans presided at a meeting of the WVU Liaison Committee of the State Medical Association which was held earlier in the afternoon. In addition to members of the Committee, the meeting was attended by Dean E. J. Van Liere and Dr. Clark K. Sleeth, Assistant to the Dean, and Dr. J. C. Huffman of Buckhannon, President of the State Medical Association. President Stahr and Doctor Penrod also were in attendance.

Physicians and their wives were guests at a social hour which preceded the dinner meeting.

The program for the one-day meeting was arranged by Drs. George F. Evans and L. E. Neal, co-chairmen of the University Alumni Committee, working with Dr. R. T. Humphries, chairman of the program committee of the Harrison County Medical Society.

## ACS Clinical Congress in San Francisco

The 46th Annual Clinical Congress of the American College of Surgeons will be held in San Francisco. October 10-14, 1960. Information concerning the program may be obtained by writing Dr. William E. Adams, Secretary, American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

Guest speakers and other dignitaries are shown at the special observance of the 93rd anniversary of the founding of West Virginia University, which was sponsored by the Harrison County Medical Society in Clarksburg on February 4. Seated, left to right, Drs. L. Dale Simmons, Clarksburg; John W. Hash, Charleston; D. E. Greenelch, Wheeling; Kenneth E. Penrod, Morgantown; Dean E. J. Van Liere, Morgantown; University President Elvis J. Stahr, Jr., and Clark K. Sleeth. Standing, Drs. George F. Evans, Richard V. Lynch, Jr., L. E. Neal and Robert S. Wilson, all of Clarksburg; J. C. Huffman, Buckhannon; Andrew J. Weaver and Harry T. Linger, both of Clarksburg. (Photo courtesy of The Clarksburg Telegram).

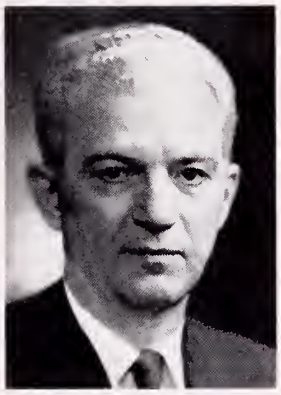
## Regional Conference on Aging In Baltimore, Mar. 30-31

Dr. E. Lyle Gage of Bluefield and Dr. George F. Evans of Clarksburg, both past presidents of the West Virginia State Medical Association, have accepted invitations to appear on the program at a Regional Conference on Aging in Baltimore, Maryland, March 30-31.

### Mrs. John F. McCuskey on Program

Mrs. John F. McCuskey of Clarksburg, a past president of the State Auxiliary, will also appear on the program. She has been active in civic and community affairs for many years and this month will be elevated to the presidency of the West Virginia Federation of Women's Clubs.

E. Lyle Gage, M. D.



George F. Evans, M. D.

Sponsored by the American Medical Association, the two-day conference will be held at the Southern Hotel. Six state medical associations will co-sponsor the Baltimore meetings. These include West Virginia, Virginia, Maryland, Delaware, New Jersey and the District of Columbia.

The theme will be "Meeting the Challenge of Added Years" and it is expected that the conference will be attended by representatives of agriculture, industry, labor, health professions, churches, schools, business, government, women's organizations, communications media, and civic organizations.

### State Physicians to Participate Actively

Doctor Gage, who is chairman of the Committee on Aging of the State Medical Association, will serve as a member of a panel for discussion of the topic, "Meeting the Challenge to Society," which is scheduled for Wednesday morning, March 30, at 9:30 o'clock.

Later that morning, Mrs. McCuskey will participate in another panel discussion on "Meeting the Challenge to Individual and Family."

Doctor Evans, who is chairman of the Council, will serve as presiding officer at the Wednesday afternoon session. Dr. Theodore G. Klumpp of New York City and Dr. Edward L. Bortz of Philadelphia, a past president of the AMA, will be among the speakers at that session.

Registration for the meeting will open at 8:30 A. M. on Wednesday morning, March 30, and the first speaker on the program will be Dr. David B. Allman of Atlantic City, New Jersey, a past president of the AMA. His subject will be "Medicine's Blueprint for the New Era of Aging."

The luncheon speaker that day will be Dr. Louis M. Orr of Orlando, Florida, who is president of the American Medical Association.

Dr. Frederick C. Swartz of Lansing, Michigan, chairman of the AMA Committee on Aging, recently stated that "we need to explore the opportunities for positive health and meaningful living among older people through exercise of individual, group and community initiative."

"With nine per cent of the nation's population now over 65 and the percentage increasing," he said, "it is important for every American to give thoughtful consideration to the aging process and its implications—to individuals and society alike."

The Baltimore conference is one of four regional meetings sponsored by the AMA. Others have been, or will be held in San Francisco, New Orleans and Atlanta.

## Medical Technologists Society To Meet In Charleston, Apr. 29-30

The annual meeting of the West Virginia State Society of Medical Technologists will be held at the Daniel Boone Hotel in Charleston, April 29-30. The following scientific program will be presented during the two-day meeting:

"Bacteriology in a Hospital Laboratory."—Mr. Guide Iannarelli, Principal Bacteriologist, Hygienic Laboratory Division, W. Va. Department of Health, Charleston.

"Some Merits of Starch Electrophoresis in the Study of Serum Lipids Fraction."—Dr. Krishna P. Misra, Charleston Memorial Hospital Laboratory.

"Practical Application of Radioactive Iodine in Diseases of the Thyroid."—Mark H. Wholey, M. D., Radiologist, Charleston Memorial Hospital.

"A Review of General Histological Techniques."—Jean H. Barr, Student Technologist, West Virginia University, Morgantown.

"Histochemical Methods in the Making."—Peter Ladewig, M. D., Pathologist, Charleston General Hospital.

"The Laboratory Diagnosis of Diabetes Mellitus."—Benjamin Newman, M. D., Pathologist, Thomas Memorial Hospital, South Charleston.

"Radioactive Isotopes in Hematology."—Grover B. Swoyer, M. D., Pathologist, Charleston Memorial Hospital.

There will be a social hour on Friday evening, April 29, immediately preceding a buffet dinner. A dance has been arranged for later that evening.

On Saturday morning a breakfast will be served at the Daniel Boone for all of the members of the Society.

## Dr. Paul Elkin Elected Fellow of ACR

Dr. W. Paul Elkin of Charleston has been elected a Fellow of the American College of Radiology.

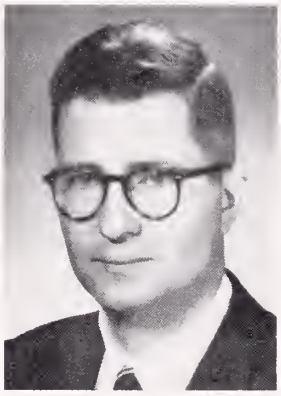
## West Virginia Chapter, ACS, To Meet At The Greenbrier, April 1-2

The West Virginia Chapter of the American College of Surgeons will hold its annual meeting at The Greenbrier in White Sulphur Springs, April 1-2. Dr. Kenneth G. MacDonald of Charleston, the president, will preside at the two-day meeting.

Several out-of-state surgeons have accepted invitations to appear as guest speakers and a number of West Virginia surgeons and residents in training will also present papers. Prizes will be awarded for the two best papers presented by residents.

Dr. James D. Hardy of Jackson, Mississippi, Professor of Surgery, University of Mississippi School of

George S. Phalen, M. D.



James D. Hardy, M. D.

Medicine, will present two papers during the meeting: "Clinical Shock—Causes and Management," and "Complications of Gastric Surgery."

Dr. George S. Phalen of Cleveland, Ohio, Assistant Professor of Surgery at the Frank E. Bunts Educational Institute, will also present two papers: "Soft Tissue Tumors of the Hand," and "Principles of Tendon Repair."

Another out-of-state speaker will be Dr. H. Glenn Bell of San Francisco, Associate Professor of Surgery at the University of California, who will speak on a surgical subject of general interest.

Dr. Kenneth E. Penrod, Vice President-Medical Affairs, West Virginia University, will attend the meeting and discuss the "Projected Clinical Operation of the West Virginia University Medical Center."

The following is a list of West Virginia surgeons who will present papers, together with their subjects:

"Carcinoma of the Cervix."—Neopito L. Robles, M. D., and Karl J. Myers, M. D., Philippi.

"Fractures of the Pelvis."—George Miyakawa, M. D., Harold B. Sunday, M. D., and Tong Hyun Chang, M. D., Charleston.

"Liver Function Tests."—William D. McClung, M. D., and Valerio Zivec, M. D., Charleston.

"Liver Biopsy."—T. Kerr Laird, M. D., Montgomery.

"Cytocidal Therapy."—Ben I. Golden, M. D., Elkins.

"Syme's Amputation and Diabetic Gangrene."—Robert L. Bradley, M. D., and Anthony F. Karich, M. D., Huntington.

"Aortic Thrombosis."—T. E. Nesper, M. D., Wheeling.

"Experiences with Femoral Prosthesis."—C. B. Buffington, M. D., and Louis Vasquez, M. D., Wheeling.

"Internal Carotid Artery Occulsion."—William F. Hillier, Jr., M. D., Bluefield.

A business meeting and election of officers for the coming year will be held at the conclusion of the scientific program on Saturday morning. Dr. George R. Callender, Jr., of Charleston, will present a report on the activities of the Trauma Committee of the American College of Surgeons, and there will be a discussion of fee schedules throughout the state and a computation of average fee schedules in the more common surgical procedures.

In addition to Doctor MacDonald, other officers of the Chapter are Dr. Ray E. Burger of Welch, vice president, and Dr. Victor S. Skaff of Charleston, secretary-treasurer. The councillors are Drs. John O. Rankin, Wheeling, William D. McClung, Charleston, Charles D. Hershey, Wheeling, and Charles M. Scott, Bluefield.

A cordial invitation to attend the meeting has been extended by the West Virginia Chapter to all practicing physicians in the state.

Further information concerning the program may be obtained by writing to Dr. Victor S. Skaff, Secretary-Treasurer, West Virginia Chapter, ACS, 807 Atlas Building, Charleston 1, West Virginia.

## Annual Congress in Oph. & Otol. At Gill Memorial Hospital

The 33rd Annual Spring Congress of the Gill Memorial Eye, Ear and Throat Hospital and the Elbyrne G. Gill Eye and Ear Foundation will be held at the Patrick Henry Hotel in Roanoke, Virginia, April 4-9.

More than 20 prominent physicians and surgeons will appear on the program as guest lecturers. The program for the six-day meeting is designed as a refresher course in ophthalmology, otolaryngology and allied specialties. The first Congress was held in 1927 and was the first recognized refresher course in ophthalmology and otolaryngology given by a hospital or medical school in the United States.

Dr. Alton Ochsner of New Orleans and Dr. John R. Heller, director of the National Cancer Institute, National Institutes of Health, will be among the speakers. They will also appear as guest speakers at a meeting of the Roanoke Academy of Medicine on Monday evening, April 4.

The annual banquet for physicians and their wives will be held at the Hotel Roanoke on Wednesday evening, April 6. The guest speaker will be Clem D. Johnston of Roanoke, a past president of the United States Chamber of Commerce.

The matriculation fee for the course will be $80. For those registering for one-half of the program, the fee will be $40. Further information may be obtained by writing to Dr. E. G. Gill, Box 1789, Roanoke, Virginia.

## Annual AAGP Scientific Assembly In Philadelphia, Mar. 21-24

Dr. Thomas H. Blake of St. Albans and Dr. Seigle W. Parks of Fairmont will represent the West Virginia Chapter of the American Academy of General Practice as delegates to the 12th Annual Scientific Assembly of the AAGP in Philadelphia, March 21-24. The alternates are Dr. Halvard Wanger of Shepherdstown and Dr. Logan W. Hovis of Parkersburg.

More than 7,000 physicians and guests are expected to attend the four-day meeting which will feature 35 prominent speakers, 127 scientific and 219 technical exhibits. The scientific program will be presented at Convention Hall.

The Academy's policy-making Congress of Delegates will convene at the Bellevue-Stratford Hotel on Saturday afternoon, March 19. Delegates from the Academy's 50 state chapters, plus the District of Columbia and Puerto Rico, will meet several times prior to adjournment on Monday.

The president's reception and dance will be held at the Bellevue-Stratford Hotel on Wednesday evening, March 23. Academy officers and their wives will receive guests at this social highlight of the meeting.

Preceding the reception, Dr. John G. Walsh of Sacramento, California, the president elect, will receive the gavel from Dr. Fount Richardson of Fayetteville, Arkansas, the retiring president.

Of unusual interest to those attending the meeting will be the modern office building that will be erected inside Convention Hall. The 2,000 square-foot building will include complete examination and diagnostic facilities, laboratory equipment, two offices and a waiting room.

The building will be erected by the Sears Roebuck Foundation as part of its project to help find doctors for small rural communities.

Additional highlights of the meeting will include the presentation of 20 $1,000 general practice residency training awards to interns or young physicians who have completed their military training. The program is carried out through a grant from Mead Johnson & Company of Evansville, Indiana.

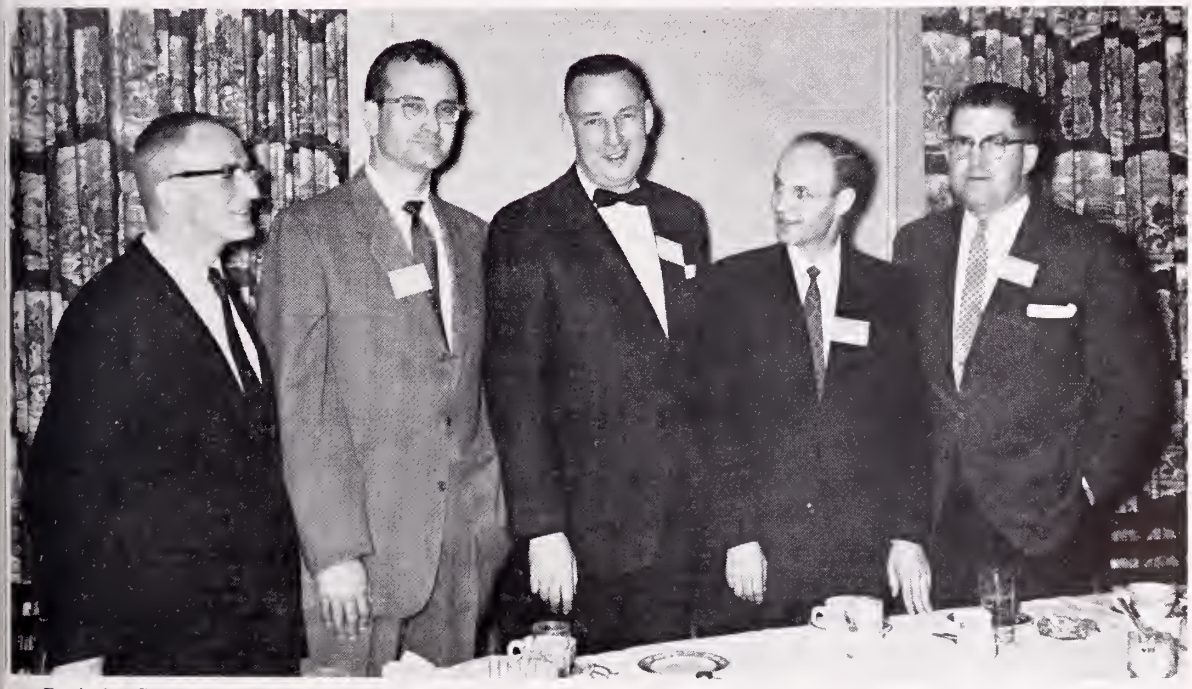
The two Academy members who have contributed the most significant scientific articles published in *GP*, official publication of the Academy, during 1959 will receive the Ross Awards, worth $1,000 each and presented through the cooperation of Ross Laboratories of Columbus, Ohio.

## Annual Meeting of Medical Assistants At Blackwater Falls, May 21-22

The Annual Meeting of the West Virginia Association of Medical Assistants will be held at Blackwater Falls Lodge, near Davis, May 21-22.

There will be a registration fee of $8.00. Nonmembers may attend, but will have no voice in the business meetings. Reservations must be made directly with the Lodge.

Mrs. Thomas G. Raisbeck of Charleston is president of the Association and Mrs. Virginia Goddin of Elkins, convention chairman.



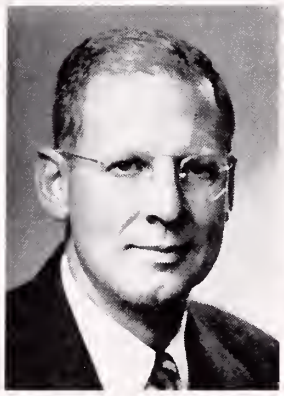
**David M. Cleary of Upper Darby, Pennsylvania, (center), free-lance science writer and executive secretary of the Pennsylvania Academy of General Practice, was the guest speaker at a dinner meeting sponsored by the Kanawha Medical Society in Charleston on February 3 and attended by physicians and members of the various news media. Left to right, Dr. William B. Rossman, vice president of the Society; Dr. John T. Chambers, chairman of the Public Relations Committee; Mr. Cleary; Dr. Milton J. Lilly, Jr., the president; and Dr. Carl B. Hall, immediate past president.**

## W. Va. Acad. Oph. and Otol. To Meet At The Greenbrier, April 10-12

The 13th Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology will be held at The Greenbrier in White Sulphur Springs, April 10-12. Dr. N. K. Joseph of Wheeling, the president, will preside during the three-day meeting.

Registration will open at noon on Sunday, April 10, and several committee meetings have been scheduled for that afternoon. There will be a social hour and dinner that evening.

The first general scientific session will be held on Monday morning, April 11, following an address of welcome by Doctor Joseph at nine o'clock. The session will be adjourned at one o'clock and the afternoon will be left open for various committee meetings and recreation. A social hour will be held that evening prior to the dinner hour.



Charles E. Iliff, M. D.

Oscar T. Becker, M. D.

The second general session will be held on Tuesday morning, April 12, beginning at nine o'clock. A business meeting and election of officers will be held following the scientific program.

Five prominent physicians have accepted invitations to appear as guest speakers during the meeting. The following program will be presented:

"The Surgical Management of Glaucoma" (Part I and Part II)—Harold G. Scheie, M. D., Professor of Ophthalmology, University of Pennsylvania School of Medicine, Philadelphia.

"Adult Ocular Tumors—Newer Surgical Techniques."—Charles E. Iliff, M. D., Associate Professor of Ophthalmology, Johns Hopkins University School of Medicine, Baltimore, Maryland.

"Pediatric Ocular Tumors."—Helen J. Ossofsky, M. D., Assistant Professor of Pediatrics, Georgetown University School of Medicine, Washington, District of Columbia.

"Plastic Surgery in Otolaryngology."—Oscar T. Becker, M. D., Clinical Associate Professor of Otolaryngology, University of Illinois School of Medicine, Chicago.

"Modern Treatment of Otosclerosis and Surgery." —John T. Dickinson, M. D., Department of Otology, University of Pittsburgh School of Medicine, Pittsburgh.

In addition to the subjects listed above, each speaker will present a second paper and the subjects will be included in the official program.

Officers of the Academy are as follows:

Dr. N. K. Joseph of Wheeling, president; Dr. John A. B. Holt of Charleston, president elect; Drs. William K. Marple and Albert C. Esposito, both of Huntington, vice president and secretary-treasurer, respectively; and Drs. James T. Spencer of Charleston and William F. Beckner of Huntington, directors.

Doctor Esposito is chairman of the scientific committee which is arranging the program for the meeting, and the other members are Drs. Edwin M. Shepherd of Charleston, Worthy W. McKinney of Beckley, Ralph W. Ryan of Morgantown, and Lyle B. McGinnis of Huntington.

A cordial invitation to attend the meeting has been extended by the Academy to all practicing physicians in the state. The registration fee for non-members will be $10, which includes the social hours and other Academy functions.

Further information concerning the program may be obtained by writing to Dr. Albert C. Esposito, Secretary-Treasurer, West Virginia Academy of Ophthalmology and Otolaryngology, First Huntington National Bank Building, Huntington, West Virginia.

## Tri-State TB Case Conference In Roanoke, Mar. 20-22

The Eighth Tri-State Tuberculosis Case Conference will be held at the Hotel Roanoke in Roanoke, Virginia, March 20-22. The Conference is being sponsored by the Trudeau Societies of North Carolina, Virginia and West Virginia.

The registration desk will be open on Sunday afternoon, March 20, at four o'clock, and Dr. Julius L. Wilson of New York City will deliver an address that evening at eight o'clock.

Dr. Hugh S. Edwards, superintendent of Pinecrest Sanitarium in Beckley, will present a report on "consecutive admissions" at the meeting on Monday, March 21. Dr. Carl H. Pfuetze of Chicago will serve as moderator at the morning session, and Dr. John S. Harter of Louisville will be the moderator at the afternoon session.

Dr. William Parson of Charlottesville will be the moderator at the final session on Tuesday morning, March 22.

West Virginia physicians who expect to attend the conference are urged to make their own reservations promptly with the management at the Hotel Roanoke.

### State Physicians Attend ACP Meeting

More than 25 West Virginia physicians attended a regional meeting of the American College of Physicians which was held at the Ohio State University College of Medicine in Columbus, January 28-30. Physicians from West Virginia, Ohio and Western Pennsylvania were in attendance.

## Two-Day PG Conference Planned At University of Virginia

A postgraduate conference on "Vector Electrocardiography" will be presented at the University of Virginia School of Medicine in Charlottesville, March 25-26.

Sponsored by the Cardiovascular Section of the Department of Internal Medicine, the course will be presented in the form of lectures, demonstrations and practice sessions with emphasis on both the theoretical and practical aspects of vector electrocardiography.

The registration fee is $40 and enrollment is limited to 50 physicians. Twelve hours of Category I credit will be allowed by the American Academy of General Practice for attendance at the two-day conference.

Further information may be obtained by writing to Mrs. Ruth K. Edwards, Secretary, Postgraduate Conference, University of Virginia School of Medicine, Charlottesville, Virginia.

### Auto Emblems Available

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

## Symposium on Problems of Newborn In Huntington, March 31

The Annual Spring Clinical Session of the West Virginia Pediatric Society will be held at the Hotel Frederick in Huntington on March 31. This all-day session, which will open at 10:00 A. M., will be in the nature of a symposium on the problems of the newborn.

The entire program will be presented by members of the staff of the Children's Hospital of the Ohio State University College of Medicine, Columbus.

A cordial invitation has been extended to interested physicians to attend the session. Reservations should be made with Dr. Henrietta Marquis, Secretary, West Virginia Pediatric Society, Room 451, 1800 Washington Street, East, Charleston 5, W. Va.

### Relocations

Dr. Charles P. Winkler of Stone, Kentucky, has moved to Williamson where he is associated in general practice with Dr. A. H. Henderson. They have offices at 114 E. Second Avenue.

* * * *

Two physicians have recently become members of the staff of the Bluefield Sanitarium in that city. Dr. John J. Bryan, who has practiced for the past two years in Houston, Texas, is now a staff member in the department of pathology, and Dr. Robert W. Neilson, Jr., who recently completed a residency at the West Tennessee Tuberculosis Hospital in Memphis, Tennessee, has accepted appointment to the staff of the department of thoracic surgery.

### Spring Meeting of MLB, April 18

The spring meeting of the Medical Licensing Board will be held at the New State Office Building in Charleston on April 18, 1960, for the purpose of examining applicants to practice medicine in West Virginia by reciprocity with other states.

## Doctor Vest Honored for Services To the Handicapped

Dr. Walter E. Vest of Huntington was awarded a "Citation for Meritorious Service" during a banquet held in connection with a statewide institute on Vocational Rehabilitation of the Aging, at the West Virginia Rehabilitation Center in Institute on Monday, January 25.

The award was presented to Doctor Vest by F. Ray Power, Director of the West Virginia Division of Vocational Rehabilitation, on behalf of the "President's Committee on Employment of the Physically Handicapped." The citation is as follows:

"Doctor Vest has been closely associated with West Virginia public and voluntary organizations serving handicapped people. He has supported legislation, spoken before organizations, published articles relative to the handicapped, and has provided medical services without cost to many needy handicapped citizens. Along with medical service, Doctor Vest has guided and counseled handicapped patients and assisted them in becoming community assets rather than liabilities."

The principal speaker at the banquet was Senator Jennings Randolph of West Virginia. He was accompanied by Senator Hubert H. Humphrey of Minnesota, who was in Charleston for a speaking engagement.

More than 200 persons attended the two-day meeting which was sponsored by the West Virginia Division of Vocational Rehabilitation and West Virginia State College, in cooperation with the Office of Vocational Rehabilitation of the United States Department of Health, Education and Welfare.

Dr. Walter E. Vest of Huntington receives a "Citation for Meritorious Service" from F. Ray Power, State Director of Vocational Rehabilitation, during a conference at the Rehabilitation Center in Institute on January 25. The principal speaker was Senator Jennings Randolph, who is shown seated on Doctor Vest's right.

## Medical Meetings, 1960

The following is a partial list of national, state and district medical meetings scheduled for 1960:

Mar. 20-22—Tri-State TB Case Conf., Roanoke, Va.
Mar. 21-24—American Academy of General Practice, Philadelphia.
Mar. 31—Spring Clinical Session, W. Va. Pediatric Society, Huntington.
Apr. 1-2—W. Va. Chap., ACS, White Sulphur Springs.
Apr. 4-8—ACP, San Francisco.
Apr. 10-12—W. Va. Acad. Oph. & Otol., White Sulphur Springs.
Apr. 18—Medical Licensing Board, Charleston.
Apr. 21-22—Carolinas-Virginias Hospital Conference, Roanoke, Va.
Apr. 29-30—W. Va. State Society of Technologists, Charleston.
May 6-8—W. Va. Chap. AAGP, Charleston.
May 12-13—W. Va. PH Assn., Bluefield.
May 21-22—W. Va. Assn. Medical Assistants, Blackwater Falls Lodge.
June 13-17—AMA Annual Meeting, Miami Beach, Fla.
**Aug. 25-27—93rd Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.**
Sept. 13-15—National Cancer Conf., Minneapolis.
Sept. 14-16—Southern Trudeau Soc., Charleston, S. C.
Sept. 22-24—W. Va. Hospital Assn., White Sul. Springs.
Oct. 21-23—PG Institute, Martinsburg.
Oct. 31-Nov. 3—Southern Medical, St. Louis.
Nov. 29-Dec. 2 — AMA Clinical Meeting, Washington, D. C.

### Change in Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston 24, West Virginia.

## Chas. N. Straughan Named By Governor As Executive Assistant

Mr. Charles N. Straughan of Logan, who has served as State Compensation Commissioner since December, 1958, has been named by Governor Cecil H. Underwood as his executive assistant. He assumed his new duties early in February.

He succeeds K. Wayne Swiger of Clarksburg who tendered his resignation last October in order to accept a position in the postal service.

Mr. C. R. Nutter of Philippi, deputy compensation commissioner, has been named by the Governor to succeed Mr. Straughan as State Compensation Commissioner.

## Robert Butts New Executive Secretary Of Southern Medical

Mr. Robert F. Butts of Birmingham, Alabama, business manager of the Southern Medical Association, has been named executive secretary-treasurer of the 14,000-member group. He also retains his duties as business manager for the *Southern Medical Journal.*

Mr. Butts succeeds V. O. Foster, also of Birmingham, who has been named professional relations counselor. Mr. C. P. Loranz remains as advisor and special consultant.

The 54th annual meeting of the Southern Medical will be held in St. Louis, October 31-November 3, 1960.

## Mental Health Training Grants Awarded to Five in State

The Southern Regional Education Board recently announced that five in-service grants totaling $1,280 have been awarded to personnel at the Huntington State Hospital under the Board's program in mental health training and research.

The grants were made to Mr. and Mrs. Stanford Walls, and Mrs. Cassie F. Kelly, all of whom are employed as psychiatric aides at the hospital. Other recipients were Mrs. Josie Mullins, charge attendant, and Dr. J. C. Ghersi, staff physician.

These grants, first made to West Virginia personnel, are links in a regional program to extend and improve mental health research and practices. The Board recently received a grant for training exchanges of mental health personnel in clinics of the region.

## AMA Plans To Organize 'Fifty Year Club'

Dr. J. H. McCurry of Cash, Arkansas, has been authorized by the American Medical Association to spearhead the organization of a Fifty Year Club in the AMA. Physicians who have been in practice 50 years or more will be eligible for membership.

The first meeting of the organization will be held during the AMA Clinical Meeting in Washington, D. C., November 29-December 2, 1960.

Physicians interested in joining the Fifty Year Club should write Doctor McCurry in Cash, Arkansas.

## World Medical Assn. To Meet in Berlin

The 14th General Assembly of The World Medical Association will be held at Convention Hall in Berlin, Germany, September 15-22. The German Medical Association has scheduled its own annual meeting in conjunction with the General Assembly and the opening and closing plenary sessions of the two organizations will be held together.

Physicians throughout the United States are invited to attend the week-long meeting. Further information may be obtained by writing to Dr. Louis H. Bauer, Secretary-Treasurer, World Medical Association, 10 Columbus Circle, New York 19, New York.

## Nutrition Symposium in Boston, May 19

A symposium on "Nutrition in Tooth Formation and Dental Caries" will be presented by the Council on Foods and Nutrition of the American Medical Association at the Statler Hotel in Boston on May 19. Cosponsors are the Harvard School of Dental Medicine and the Massachusetts Medical and Dental Societies.

# The West Virginia Medical Journal

April, 1960 Vol. 56, No. 4

## Management of Chronic Vascular Headache*†

### (Clinical Observations)

*Leo H. Criep, M. D.*

Chronic headache is one of the most frequent complaints heard in medical practice. The patient suffering with chronic, recurrent headache makes the rounds from one physician to another, seeking relief of a condition which seriously taxes his ability to function as a normal individual. He frequently receives at best only cursory attention and usually and eventually is dismissed with a shrug of the shoulders. He is told that his difficulty is with his "nerves" and that he simply will have to "pull himself together." Thus he gains the impression that no one really is interested in him or in his condition. He becomes discouraged and frustrated. The truth is that there is no justification for this hopeless medical attitude, for a great deal can be done for these patients. In order to accomplish this end, however, it is essential to be thoroughly familiar with the various causes of pain in the head, to know something about differential diagnosis and to master basic principles of management.

### *Allergy Number*

**The scientific section of this issue of The Journal is devoted to the publication of papers presented before an open meeting of the West Virginia State Society of Allergy, held during the 92nd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20, 1959. Included are the papers presented as part of a panel discussion on "Repository Pollen Therapy," sponsored by the Society.**

**In addition, a paper presented by J. Warrick Thomas, M. D., before the annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology at The Greenbrier, June 9, 1959, appears in this issue.**

### *The Author*

• **Leo H. Criep, M. D., Associate Professor of Medicine and Chief of Allergy Clinic, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.**

#### Outline of Presentation

It is the purpose of this presentation to discuss primarily the problem of chronic vascular headache. Before doing so, however, I shall say a few words about other types of headache with which chronic vascular headache may be confused. The causes of head pain are as follows: systemic diseases, febrile, such as pneumonia, and non-febrile conditions such as alkalosis and hypotension; degenerative and circulatory diseases; diseases of metabolism; toxemias; diseases of the eye and teeth, i. e., glaucoma, malocclusion of the teeth; post-traumatic headache, intracranial infections; meningitis, encephalitis; spinal puncture headache; neuralgias and neuritides; intracranial tumors; cervical arthritis; primary fibrositis.

Because differential diagnosis frequently is difficult, it is necessary to give patients suffering with chronic headache a complete and careful medical survey. This should include, in addition to a routine physical examination and laboratory procedures, special investigation such as neurologic, rhinologic, radiologic and electroencephalographic studies, as indicated. In instances of chronic vascular headache in which sensitization plays a role, an allergic study is done. Thus, tragic and humiliating diagnostic mistakes may be avoided. It should not be assumed that a patient's headache is psychosomatic in origin

merely because of evidence of emotional disturbance. It is sad to discover after a prolonged course of psychotherapy that the head pain is due to tumor of the brain, a condition for which treatment might have been effective had the correct diagnosis been made early.

### Chronic Vascular Headache

Chronic vascular headache includes the following conditions: migraine, histamine cephalgia, allergic headache, tension headache and pain in the head associated with nasal allergy and sinusitis. These are for the most part reversible. The non-reversible types of chronic vascular headache include temporal arteritis and hypertension headache, conditions associated with inflammatory and degenerative arterial changes.

### Role Of Allergy In Chronic Vascular Headache

There is considerable disagreement as to the incidence of allergy as a factor in chronic vascular headache other than that associated with allergic rhinitis. The basis for this condition is, of course, allergic. On the other hand, uncomplicated tension headache is not on an allergic basis. What then is the role of allergy in such chronic vascular headaches as migraine, histamine cephalgia and true allergic headache? Here again, statistical evidence varies as to the extent and frequency of an allergic etiology. There is no doubt that in many instances there is incontrovertible evidence that sensitivity, especially to foods, brings on an attack. It is only natural that the internist oriented in allergy and interested in the headache problem will see more cases of this type.

A review of our own records for the past six years reveals the following: Two hundred ninety-five patients consulted us for headache which upon investigation proved to be chronic vascular headache other than that due to allergic rhinitis.

The table indicates the role played by allergy as an etiologic factor. Sensitivity to various substances, inhalants as well as foods, is important in all cases of allergic rhinitis and allergic headache. Of 43 migraine patients, allergy, especially to foods, was proved to be clinically significant in twelve. Histamine hypersensitivity is present in all cases of histamine cephalgia. There were 44 patients whose headache was undetermined in origin but possibly was vascular in type. This represents a conservative estimate of allergy incidence. At the same time, it is sufficiently high to justify a careful search for allergic causes. Such a survey followed by suitable avoidance directions is indeed rewarding. It should also be pointed out that most patients present clinical findings characteristic of more than one type of vascular headache. Thus histamine cephalgia has many of the features of migraine and migraine patients also frequently have tension headache.

**ROLE OF ALLERGY IN CHRONIC VASCULAR HEADACHE**

| | *No. of Patients* | *Allergic Cause* |
|---|---|---|
| Allergic Rhinitis | — | All |
| Migraine | 43 | 12 |
| Histamine Cephalgia | 5 | 5 |
| Allergic Headache | 19 | All |
| Tension | 184 | 0 |
| Undetermined | 44 | |
| Total No. of Patients | 295 | |

### Mechanism Of Pain In Chronic Vascular Headache

Pain in chronic vascular headache is due to distention, dilatation and traction of the arteries and veins of the head, namely, the branches of the external and occasionally of the internal carotid arteries. The branches of the external carotid arteries are the supraorbital, the frontal, the occipital, the postauricular and the temporal. The branches of the internal carotid artery are the anterior and middle cerebral arteries, the vertebral, the basilar and the ophthalmic artery. In addition, there is, as a rule, associated reflex spasm of the muscles of the scalp and of those of the neck. This spasm interferes with the local blood supply, producing ischemia and further adding to the severity of the pain.

Pain is also brought about by traction on the large arteries at the base of the brain and on the middle meningeal artery. Fatigue further contributes to this mechanism, for it produces blood vessel atony which, in turn, increases the tendency to pulsation and dilatation. Objective evidence of this explanation for the pain is furnished by the fact that the administration of ergotamine tartrate relieves the pain. Such relief is brought about because this drug causes vasoconstriction and thus decreases the amplitude of arterial pulsations. Distention and mechanical dilatation of the temporal artery in a migraine patient will bring about pain in the area supplied by this artery; ligation of the artery will produce temporary diminution of the pain; also, manual pressure on the temporal, occipital and common carotid arteries during an attack of migraine frequently reduces the severity of the paroxysm.

There has been some work done which would indicate that acetylcholine also is involved in

*Presented before an open meeting of the West Virginia State Society of Allergy, held during the 92nd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20, 1959.

†From the Allergy Clinics, University of Pittsburgh School of Medicine, and the Montefiore Hospital, Pittsburgh, Pennsylvania.

Submitted to the Publication Committee, August 17, 1959.

bringing about dilatation and relaxation of these blood vessels. This substantiates the view that parasympathetic nervous system preponderance may also play a role in this condition.

### Migraine

*Clinical Features.*—The clinical picture of migraine headache is familiar to every physician. The patient, usually a female, may be of any age. The pain is paroxysmal, recurrent, deep, dull, persistent, aching, pounding or throbbing. It is unilateral (hemicrania). It follows the distribution of the branches of the external carotid artery, and is associated, in female patients, with the menstrual cycle. The patient appears ill, and is unable to carry on her normal activities. During her edematous stage, the blood vessels (the temporal artery) are palpable, swollen, large and tender. Aura and scotoma precede the onset of the headache. There is marked photophobia, nausea and vomiting.

The patient shuts himself up in a room with the blinds drawn and the doors closed and prefers to be left alone. He cannot tolerate any noise or the odor or sight of food. The pain lasts from a few hours to a day; in many instances, it is associated with polyuria, excessive sweating and pain in the occiput. There is a family history of migraine in many cases. As a rule, the headache disappears after the onset of menopause.

Alvarez has described "the migraine personality" as characteristic of the emotional makeup of migraine. The patient is a perfectionist. He takes his responsibilities quite seriously. He is high strung and tense. Functional upheavals, personal problems, competition, strife, indecision and emotional crises precipitate an attack. Once the attack is over, the patient is left weak and prostrated.

### Migraine Equivalents

Certain conditions have been recognized as migraine equivalents. These include abdominal pain associated with nausea and vomiting, occasional pain in the chest and, finally, the so-called ophthalmic migraine characterized by ocular symptoms involving dilated pupils, hemianopsia and scotomata.

### Stages Of Migraine Headache

The course of migraine headache may be divided into three stages: first, a short-lived period, perhaps not more than one-half hour, marked by scotoma and vasoconstriction. If vasodilators are given at this time in suitable doses, the scotomata are relieved.

The second stage is the vasodilating phase. In addition to the characteristic pain in this period, there occurs reflexly, spasm of the muscles of the occipital area and of the neck. This is accompanied by local tenderness.

The last or the third stage is that of edema. This is probably brought on by increased capillary permeability and dilatation. It is entirely possible that histamine and perhaps acetylcholine play a role in this mechanism. In about 5 per cent of all cases, the vasospastic stage continues and is not replaced by vasodilatation. This has been referred to as "white" migraine in contrast to the vasodilating type or "red" migraine. It is in the vasoconstricting migraine that relief is not obtained from the administration of vasoconstricting agents. In all probability, it is the branches of the external carotid which are involved in migraine, because one cannot demonstrate vasodilatation in the retinal artery during the headache. The retinal artery is a branch of the internal carotid artery.

### Treatment

Many of the principles of treatment which apply to migraine headache are equally applicable to some of the other headaches of vascular origin. Co-existing pathology such as anemia and gastrointestinal disturbances are removed or corrected.

Vascular headaches are deeply affected by tension. As a matter of fact, tension headaches frequently complicate migraine, histamine cephalgia and the headaches associated with nasal allergy. Both the intensity of the patient's emotional reaction and his ability to lead a normal life are affected by the headache as well as by the impending threat of a paroxysm. The patient dreads these recurrent attacks. These influences leave a mark upon his personality. He may become introverted, submissive and lead the life of a cripple, demanding a great deal of sympathy and attention. Not being able to obtain relief, he is frustrated and discouraged. Or he may overcompensate and become extroverted, aggressive and hostile. Under the impact of anxiety, fear or some other emotional explosion, the headache becomes more frequent and unbearable.

These patients show evidence of chronic emotional strain as a result of various conflicts. Their emotions may not find an outlet, and so their repressive drives lead to maladjustment which affects the clinical course of their complaint. For all these reasons it is essential that the sufferer be given the benefit of informal psychotherapy. It is certainly neither necessary nor wise always to obtain for him the services of a psychiatrist. Any physician interested in such patients, any physician who will allow a given amount of time

regularly and periodically for a conference with his patient, can perform the service adequately. The physician must consider his patient as a suffering human being in need of sympathetic care and kind understanding. He must show a genuine interest in the patient's personal problems and life situation. He conducts a careful analysis of the patient's daily activities, his antecedents, his personal life, his attitude toward his environmental problems, and the amount and nature of his rest and relaxation.

The patient is taught how to regulate his mode of living, how to make the necessary adjustments, how to relax, how to be less exacting of himself and of those by whom he is surrounded. Reassurance and encouragement are needed. The patient is made to feel that at long last someone is really interested in his condition. Thus, an opportunity is given for ventilation and discussion. Such conferences lead to a better mutual understanding and produce valuable and improved patient-physician relations.

There is little doubt that there is an allergic basis in some instances of migraine. These patients present the criteria of allergic diagnosis, such as a family and a personal history of allergy. They supply the information that the ingestion of certain foods may be etiologically related to the onset of headache. In this connection, I cite the following typical case history to illustrate the allergic nature of this condition.

### Case Report

The patient, a physician aged thirty-four years, presents a family history of migraine and hay fever. For years he has had allergic rhinitis. He gives a history of paroxysmal unilateral headaches which have been present for as long as he can remember. The headaches are preceded by an aura and are accompanied by nausea and vomiting. The paroxysms last twenty-four to forty-eight hours during the course of which he cannot tolerate light, noise or food. At times, the headache is so severe that it becomes necessary to administer morphine.

He states that he dreads the approach of family dinners because they invariably bring on a headache and he ascribes its occurrence in these circumstances to the prevailing excitement.

Physical examination and laboratory tests are non-contributory. An allergic survey reveals the patient to be sensitive to chicken meat and peanuts. This was determined by skin tests, passive transfer and trial feeding of both of these foods. The sensitivity was so marked that even the ingestion of foods such as potatoes cooked in a container previously used for chicken would bring on severe paroxysms of headache. He learned to avoid any foods, such as soups, that might contain chicken stock or foods that might contain peanuts. It was realized later that chicken was served at his home on holidays and at other celebrations and for this reason these family dinners frequently ended so unpleasantly for the patient. With the institution of an allergic diet, the headaches disappeared.

Within the past few years, a blind spot developed in one eye, for the treatment of which the patient had his teeth and tonsils removed, and his sinuses operated on. It developed later that the condition was due to recurrent edema of the macula; during the course of the allergic study, it was shown that these eye symptoms could be reproduced by the ingestion of peanuts. This is of interest from the point of view of the present discussion of the pathogenesis of migraine.

### Medicinal Therapy

Medicinal treatment includes a variety of agents, the most important of which is ergotamine tartrate (Gynergen). Ergot blocks sympathetic nerve impulses in experimental animals. Its action in man is that of vasoconstriction through its direct action on the muscle wall of the smaller arteries. In addition, it has, of course, other actions. It produces contraction of the uterus, reflex bradycardia and has a tendency to affect the capillary endothelium. Therefore, ergot is contraindicated in pregnancy, coronary artery disease, hypertension, peripheral vascular disease, angina pectoris and involvement of the kidneys and liver.

Ergotamine is so specific in migraine that it can be used for diagnostic purposes. It seems most unlikely that one is dealing with a case of migraine if ergotamine is not therapeutically effective. It is important to begin its administration immediately after the onset of the headache, for the longer one waits the less effective is the treatment. As the attack of migraine continues, the arteries become swollen and edematous. If given during this stage, ergotamine is not beneficial. There are many available ergot preparations. This product may be given alone or in combination with caffeine. It is given by mouth, by injection, or rectally. Caffeine has been shown to be a vasoconstrictor when given in small doses by mouth. Thus, it may have a potentiating or synergistic effect upon the action of ergotamine. Furthermore, since it has been definitely demonstrated that edema of the brain occurs during the latter stages of migraine, and that water metabolism is disturbed during the attack, it follows that the diuretic action of caf-

feine also may be of help. Indeed, in the older textbooks one finds that black coffee was frequently a part of the treatment of migraine.

### Preparations Containing Ergot

Tablets contain ergotamine tartrate 1 mg. and caffeine 100 mg. (Cafergot-Sandoz). Two to four tablets are taken at one time during the period of aura, at the onset of the attack. Many patients who have heretofore found it necessary to take ergotamine tartrate by hypodermic obtain relief from this oral preparation. There still are, however, some patients to whom the product must be given by injection. For this purpose, the patient is given intramuscularly 0.5 cc. ampule of Gynergin (N. N. R.) which contains 0.25 mg. ergotamine tartrate. This dose may be repeated every hour until a total of 1 mg. has been given. It is not repeated in less than ten days.

Ergotamine tartrate 1 to 3 mg. may be given sublingually every two hours till a total of 10 mg. has been administered in twenty-four hours, if necessary.

In many instances rectal suppositories of Cafergot® containing ergotamine tartrate 2 mg. and caffeine 100 mg. are effective. This suppository may be repeated in one-half to one hour, if necessary. The drug must be given during the period of aura when the first warning of an impending headache occurs. Some patients have side-reactions to ergotamine. These include nausea and vomiting which may be easily controlled by the administration of atropine. If muscle soreness and weakness occur following the use of ergotamine, 10 cc. of 10 per cent calcium gluconate is given intravenously. Patients who do not tolerate these products may do well on dihydroergotamine (DHE 45). This is a dihydrogenated product of ergotoxine. Dihydrogenation of ergot reduces its toxicity but at the same time it reduces its vasoconstrictor action. Therefore, it must be given in doses twice as large as ergotamine tartrate. It may only be administered parenterally. One cc. (which is equivalent to 1 mg.) or, occasionally, 2 ccs. are administered. The dose (1 cc.) may be repeated in an hour if necessary.

Another substitute for ergotamine is methyiso-octenylamine or (Octin). This is given intramuscularly in doses of 0.5 to 1 cc. It is antispasmodic. It is contraindicated in the presence of hypertension.

Many other agents which have been employed from time to time in the treatment of migraine have proved ineffective. Among these may be mentioned calcium lactate, potassium chloride, vitamins, low fluid balance, antispasmodics and many others. Diuretics are helpful in those cases in which migraine is accompanied by increase in weight. Diamox, which is acetazolamine and acid diuretic salts such as ammonium chloride as well as a salt poor diet may be prescribed prior to the period of onset. Analgesic drugs such as acetylsalicylic acid and acetophenetidine are employed. Codeine occasionally may be administered for pain. A more recent product is dextropropoxyphene hydrochloride in a dose of 65 mg. four times daily. Analgesics may be combined with barbiturates. The dosage of tranquilizing drugs, reserpine, chlorpromazine hydrochloride (Thorazine), meprobromate (Miltown, Equanil) (2 metyl-2-N-propyl-1, 3-propanediol dicarbamate), depends on the individual patient. If the patient does not respond or responds adversely, then the drug should be discontinued. Chlorpromazine sometimes suppresses the nausea associated with migraine and may be given prophylactically for tension headache. Meprobromate is also occasionally very helpful. Opiates are contraindicated.

Other therapy which is occasionally beneficial includes oxygen inhalation; anticonvulsant drugs which are dilantin, mesantoin and methinione, are helpful in those patients who have abnormal encephalograms and occasionally aphasia and paresthesias.

Migrainous patients often will state that they have two kinds of headache. They describe one type characterized by a dull constant generalized pain in the head (the tension type), and a more severe type which comes on periodically, perhaps once or twice a month. In this type, the pain is throbbing and unilateral, although occasionally it may be bilateral and associated with nausea, photophobia and vomiting. This latter type is the migraine which frequently is obscured by the tension headache.

### Histaminic Cephalgia

This usually begins later in life. It is manifested by unilateral headache of relatively short duration. The pain may come on at night. The patient is restless and paces the floor because of the pain. It may be accompanied by homolateral nasal and eye symptoms such as lacrimation and rhinorrhea. The temporal vessels on the same side may be dilated and tender. The pain is dull, burning, boring. It is due to involvement of the branches of the external carotid artery.

It is thought that this pain is brought on by the action of histamine. Frequently, the sublingual administration of glyceryl trinitrite will precipitate an attack. Some patients are relieved

by the intravenous administration of 1 cc. of DHE 45. Histamine is used in the treatment of this condition. Histamine diphosphate is obtainable in ampules which contain 0.275 mg. of histamine diphosphate per cc. and this is equivalent to .1 mg. of histamine base. The rapid method of treatment consists in beginning with .05 cc. subcutaneously. This dose is given twice a day. The dose is increased by .05 cc. every day. Occurrence of headache or a flushing sensation indicates that the maximum dose has been reached.

Some patients may be given histamine in a dilution of 1-100,000 beginning with 0.1 cc. and increasing at weekly intervals by 0.1 cc. until 1 cc. dose is reached. If the patient shows no untoward reaction, then one proceeds with 0.1 cc. of a 1-10,000 concentration of histamine. The dose is increased at weekly intervals until 1 cc. dose is reached. If a reaction occurs when a smaller amount is received, then this amount is considered the maximum dose. It is given every week for four times, then every two weeks for four treatments, every three weeks for four times and finally once a month. Histamine in man produces increased gastric acidity, gastric hemorrhage from an unsuspected ulcer, severe headache and, occasionally, a fall in blood pressure, and urticaria. Histamine therapy is therefore contraindicated in the presence of peptic ulcer or vascular disease.

### Case Report

The patient, male, age 54, college teacher, states he has been troubled with unilateral headaches for the past fifteen years. The pain is deep and aching. There is no aura or photophobia. There are no gastrointestinal symptoms. Patient experiences lacrimation and nasal obstruction as well as rhinorrhea on the homolateral side. Exposure to cold and ingestion of alcohol will precipitate an attack. He must be up and around during a paroxysm. There are strong emotional factors. Patient reacts markedly to histamine which may induce an attack. He is an atopic individual who also presents evidence of clinical sensitivity to milk and a few other foods. Avoidance of offending allergens and histamine therapy brought about marked relief.

### Allergic Headache

This type of headache does not have the typical characteristics of migraine nor of histamine cephalgia. The patient gives a personal and a family history of allergy. There is evidence of clinical sensitivity to foods. The headache is of a vascular origin. The pain is not characteristic in its quality, persistence or distribution. This condition may be associated with other allergic manifestations. While it is not very common, it is encountered quite frequently in an allergic practice.

### Case Report

The patient, a thirty-five year old female, complains of severe frequent paroxysmal headaches. These occur on an average of two to four times per month and are made worse by excitement. The pain is distributed over the top of the head and over the occiput. Occasionally, it may involve the side of the face. The patient suspects that certain foods, particularly pork, almost invariably produce severe gastroenteritis and headache. There is an associated history of hay fever, and a family history of asthma.

An allergic survey indicates sensitivity to wheat, pork, chocolate and green peas. This sensitivity is corroborated by clinical trial as a result of the blindfold test. Allergic treatment in this patient was quite effective. The only time that she developed a headache was when she had been indiscreet about her diet.

### Tension Headache

As stated previously, this type of headache also is of vascular origin. It is frequently found related to other types of vascular headache. Every attempt is made in the treatment of this condition to improve the patient's physical condition and to pay careful attention to his disturbed emotional status. Psychotherapy is essential. Allergy plays no role in the mechanism of this condition.

### Allergic Rhinitis

In this condition the nasal mucous membrane is boggy and swollen. Hence, the area in which the ostiae of the sinuses are found also is swollen. The ostiae are occluded. There is interference with proper emptying of the sinuses. The air within the sinus cavities is trapped. Since the mucous membrane lining the sinuses is also swollen and edematous, the air within these cavities becomes compressed. It is this pressure that contributes to the so-called sinusal headache.

Since in allergic conditions the process is reversible, the air becomes rarified, the pressure is decreased when the edema is relieved and when the sinusal ostiae become open. Headache in these instances, therefore, occurs because of the fluctuations in the air pressure within the sinus cavities. It should be stated that another explanation for the pain is the inflammation about the sensitive ostiae. The quick reversal or disappearance, however, of the periodic recurrent pain in nasal allergy following the use of nasal vasoconstrictors would tend to indicate that at least in these cases infection and inflamma-

tion alone are not the only factors. The sensitivity of the ostiae to pain does play an important role in this connection. Occasionally occipital headache may occur in this condition due to reflex spasm of the muscles of the neck. Treatment is that of the underlying allergy. In addition, it includes medicinal, topical and perhaps surgical therapy, if indicated.

### Temporal Arteritis

This headache is unilateral and throbbing in nature, being associated with tenderness of the scalp and of the temporal arteries. It usually occurs late in life. It is more common in females. Similar blood vessel lesions are found elsewhere in the body, i.e., the aorta, carotid and other vessels.

The patient has a mild elevation of temperature, aches and pains, gastrointestinal symptoms, chills, leucocytosis and signs of systemic involvement. The disease is usually self-limited although it has been known to end fatally. Diplopia may be found in some instances. Blindness may occur in about 30 per cent of cases, apparently due to ischemic optic neuritis. It is frequently favorably affected by corticosteroids. Injection of the periarterial tissues with novocain gives relief. Excision of a section of the artery is helpful. Microscopic examination reveals narrowing of the lumen of the blood vessel with thickened walls which show mononuclear infiltration. Intimal sclerosis is present. Giant cells are found in the media.

### Hypertension

This form of headache is vascular in origin. It is due to dilatation and pulsation of the arteries of the head. It is caused by increased intravascular pressure and is contributed to by degenerative lesions in the arterial wall. Histamine and allergy play no role in its production.

### Summary

This paper points out the need for proper evaluation and management of the patient suffering with chronic vascular headache. Allergy plays a variable but significant role in some instances of migraine and histamine cephalgia, and an important role in allergic headache and in the headache of allergic rhinitis. Because of this, it is urged that these patients be given the benefit of a careful medical evaluation which should involve in suitable cases a complete allergic investigation. Management based on such an all-inclusive approach is rewarding and will win for the physician the everlasting gratitude of the much neglected headache patient.

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## Aging – A Community Responsibility

Social planners have conceived the idea of solving all problems of the "elders" by legislation in the form of compulsory health insurance. While the aged do have problems, only a minor portion are in the health field. Older people not only have longer but they live healthier lives as well. Good health is far more than the absence of disease and infirmity. It involves the positive state of physical, mental and social well-being. Loneliness, rejection and lack of useful activities must not be permitted.

Health insurance, on a voluntary basis, is available to this group through Blue Shield at a lower rate, thus assuring health care in home surroundings.

Responsibility for this group is not a federal, but a community project and must be assumed by family, friends, church, clubs—that complex group we call Society.—Milton A. Darling, M. D., in Journal, Michigan State Medical Society.

# The Practical Management and Prevention of Poison Ivy Dermatitis in Adults and Children*

*Morton Singer, M. D.*

Dermatitis venenata from Rhus toxicodendron (poison ivy) is a common summer ailment and a long-standing medical problem. It is an illness which ranges from a minor isolated skin lesion to a major toxic systemic reaction which, at times, has proved fatal.**[1] The diagnosis may be as obvious as the well-known tri-partate leaf which causes the dermatitis or as obscure as the many seldom-recognized variations of the poison ivy plant. Therapy, too, has a wide range of variability since it includes both oral and parenteral prophylaxis as well as a wide variety of phylactic agents for treating already existing lesions.

In this paper, a number of the most common medical problems which arise in connection with the poison ivy plant and the illness for which it is the etiologic agent will be discussed. Diagnosis, common misconceptions and active therapy will be covered. Major emphasis will be given to prophylaxis, first, because this is one of the most promising aspects of the current approach to poison ivy dermatitis and, second, because it is an area in which we have carried out research. Some of our preliminary findings will be reported below.

### Diagnosis and Common Misconceptions

Poison ivy dermatitis is a form of contact dermatitis or "dermatitis venenata." It is an allergic disease and not the result of a primary irritant.[1] The allergic principles are present in all parts of the plant which harbor resin canals, particularly in the ivy leaves, and, primarily, are chemicals known as "catechols." Poison ivy dermatitis is the most common of all contact dermatitis and must be differentiated from the hundreds of other possible etiologic agents which result in dermatitis venenata, from occupational chemicals to all varieties of substances applied to the skin including those prescribed by physicians.

In making the diagnosis of rhus dermatitis, a history of exposure is helpful in most cases. One must be aware, however, that indirect modes of exposure exist. The poison ivy allergens maintain some degree of potency for many months and may be spread through the air from burning logs with poison ivy tendrils adhering to them, and thereby produce lesions in midwinter. Spread by foamites is common at all times and may include pets, other animals and tools. Contact with the skin of persons who have active lesions may cause the dermatitis. Incidentally, spread occurs only by means of the antigens, the "catechols," and these chemicals survive heavy scrubbing as well as the application of astringents, and account for the spread of lesions from one body part to another. They remain on the skin up to three days. Contrary to common belief, the vesicles do not contain the antigen and will not spread the lesion.

Returning to the subject of diagnosis, the location of the initial lesion is of help. The backs of the fingers, the interdigital areas and the wrists and ankles are the most common sites. Onset of the dermatitis usually is abrupt and occurs, on the average, 24-48 hours after exposure (6 hours to 12 days are the reported limits of time between contact and onset[1]). The lesions are erythematous and vesicular, are usually grouped and often are linear since contact usually is made by brushing along the leaves. Pruritis and burning are common. The dermatitis usually is self-limited, lasting about 2-3 weeks, but recurrence is common. In severe cases, systemic reactions are seen and may include fever, edema and profuse extravasation of vesicular fluid.

A few other general points: No one is born immune to this dermatitis although the skin of the negro is less sensitive to exposure. Sensitivity is greatest in children and decreases or vanishes with age; once sensitivity is lost, it seldom returns. Statistically, approximately 50 per cent of young white adults are sensitive while only


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*Presented before an open meeting of the West Virginia State Society of Allergy, held during the 92nd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20, 1959.

**Two recent publications by Dr. Albert Kligman (1, 2) thoroughly review and clarify much of the basic data related to poison ivy dermatitis.

Submitted to the Publication Committee, August 21, 1959.

14 per cent of persons over 60 are found reactive.[1]

### Therapy

*Phylaxis.*—There are two major approaches to the treatment of existing lesions: topical therapy and systemic therapy. Topical therapy is best carried out by means of simple compresses and the application of standard shake-lotions such as plain calamine. Phenolated lotions are not recommended, since the poison ivy antigens contain phenolic groups and such medications may make the dermatitis more severe. Kligman[1] tested at length a great number of more specialized topical medications and concluded that they offered no advantage over these simple and basic medications. His trials included topical steroids. Gaillard[3] also found steroids unsatisfactory when used topically. Soap substitutes such as Lowila Cake, or Aveeno, are useful in place of ordinary soaps when washing areas involved in the dermatitis.

Orally ingested steroid hormones such as prednisone and prednisolone[1, 3] are effective and are indicated in more severe cases. Oral antihistaminics such as Dimetane have been useful in diminishing the pruritic response. Much controversy exists concerning the use of poison ivy antigens to treat the dermatitis. Gaillard[3] had good results without toxicity using small doses of Aqua Ivy parenterally (0.1 to 0.3 cc. of a 1:50 dilution), but Kligman[1] condemns this mode of therapy. Further work clearly is needed to clarify this aspect of active therapy, and no final conclusion may be drawn as yet.

*Prophylaxis.* — Prophylactic measures range from efforts to avoid contact with the plant to oral and parenteral antigen therapy. External prophylactic measures were thoroughly tested by Kligman who found washing, barrier creams and detoxicants (34 of these!) all without preventive value. Spraying the plant itself with chemicals such as 2,4 dichlorophenoxyacetic acid has limited value.

Reports of hyposensitization of ivy-sensitive individuals by the administration of some part of the poison ivy plant and, thereby, the poison ivy antigen, date back to Dakin, in 1829.[4] Many attempts have been made along these avenues,[2, 5] but attention here will be focused on research with the alum precipitated pyridine ivy extract (Aqua Ivy), first reported by Strauss and Spain,[6] in 1946, and the recent work of Kligman.[2] Both groups have attempted oral and parenteral prophylaxis.

To briefly review this previous work, Kligman[2] carried out prophylaxis with the rhus oleoresin and pentadecylcatechol intramuscularly and orally, and with cashew nut oil (a related plant) orally, utilizing large and often cumbersome or toxic doses of these substances. Hyposensitization was measured by direct patch testing with 3-pentadecylcatechol (one of the poison ivy catechols), and clinical standards were not applied. He found that hyposensitization could be achieved but that it lasted no longer than 6 to 8 months, as measured by his patch test procedures. He reported, however, clinical suggestions of a more lasting effect.

Parenteral prophylactic therapy with the alum precipitated pyridine ivy complex is best reviewed by Gaillard,[3] and the data reported by that observer and others consist essentially of the clinical demonstration of effectiveness. Kligman[1] utilized this material with negative results as measured by his patch test criteria, but more recently McLoughlin[8] reported hyposensitization with Aqua Ivy administered subcutaneously, using a dry pentadecylcatechol patch as his criterion of effectiveness. McLoughlin utilized a higher dosage of this material than that used by previous workers, and toxicity did not appear. His report indicates that this is an effective and practical means of prophylaxis.

Langs and Strauss[5] and Langs, Fuchs and Strauss[9] recently have reported their findings in the area of oral prophylaxis with the alum precipitated pyridine ivy extract. A clinically controlled double-blind study, a patch test study and a purely clinical study all produced favorable results. Most of the subjects were adults and side-effects were minimal. Hyposensitization in the patch test study was demonstrated to last at least one year as measured by the use of an alcoholic-ivy extract for patch testing.

### Report on Personal Research

The research to be reported here is an ongoing study of the effectiveness of the oral alum precipitated pyridine ivy complex.* The patients are predominantly children, with some adults.

The standard dosage** of this material was administered to the adults and one-half the standard dosage was administered to the children. In 1958, subjects were selected who had had poison ivy dermatitis the year before and all were positive to the pentadecylcatechol patch at dilutions of 1:1,000, 1:10,000 and 1:100,000. Two groups were formed. Group I, consisting of 40 children (ages 5-12) and 10 adults, took Aqua Ivy Tablets. Group II, consisting of 15

*This material, called Aqua Ivy Tablets, was provided by Syntex Chemical Company, Inc., 10 East 40th Street, New York City.

**0.6 mg. every other day for two weeks; then 0.6 daily for two weeks; then 1.2 mg. daily until a total of 200 tablets have been ingested.

RESULTS OF THE 1958 AQUA IVY TABLET STUDY

| Group* | No. of Patients Per Group | No. of Patients Acquiring Poison Ivy Dermatitis | % Incidence | No. Patients Patch Tested Again After Therapy | No. Becoming Patch Negative |
|---|---|---|---|---|---|
| I. Aqua Ivy Tablets | 50 (40 children 10 adults) | 1** | 2% | 15 | 6 (40%) |
| II. Placebo | 15 Adults | 4 | 27% | — | — |

*All patients had a definite history of poison ivy dermatitis and were positive to a dry pentadecylcatechol patch test.
**This child did not take the tablets regularly.

adults, took a placebo (See Table). All were exposed moderately to heavily during the poison ivy season. Of the 50 patients who took the medication, only one, a child who was highly irregular in taking the tablets, contracted poison ivy dermatitis. In contrast, 4 of the 15 control patients had poison ivy dermatitis; 3 of the 4 were subsequently placed on the pyridine ivy extract and had no further lesions. The fourth patient stopped all medication and was not followed. Fifteen of the 50 patients in Group I (Aqua Ivy group) were patch tested at the end of the season and 6 had become negative to the pentadecylcatechol patch. Side-effects were not seen.

This year, 25 subjects were added to the series. All were positive to patch testing and are being followed with blood counts and urinalyses. As of the date of this report, only two persons in this group have had poison ivy lesions and both were mild. Again, no side-effects have been seen. Thus, to date, in 78 sensitive and chronically exposed patients to whom this material was administered prophylactically, there has been a 3 per cent incidence of poison ivy lesions.

In conclusion, this work and that of others indicates that antigenic hyposensitization with poison ivy extracts is a feasible method of prophylaxis against poison ivy dermatitis. Currently, the most practical mode of this form of therapy seems to be the utilization of the alum precipitated pyridine ivy complex (Aqua Ivy) either in parenteral or tablet form.

### Summary


1. The differential diagnosis of poison ivy dermatitis is discussed. Common misconceptions are clarified.

2. Active therapy of poison ivy lesions is best undertaken with common shake lotions and compresses. Oral steroid therapy is recommended for more severe cases.

3. Both oral and parenteral prophylaxis are now possible and practical. The alum precipitated pyridine ivy complex appears to be the drug of choice. This is supported by the preliminary data presented here in which Aqua Ivy Tablets gave 50 patients significantly more clinical protection than that gained by 15 patients with a placebo. The drug reduced patch test sensitivity to negative in 6 of 15 patients tested by this means. Twenty-five additional patients have been added to the series this year, with continued excellent results.


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*. . . leisure is the finished product of efficiency.*
Grit.

# Facts, Fallacies and the Allergic Diseases—FDA's Role*

*Irvin Kerlan, M. D.*

The opportunity to meet with you to discuss the Food and Drug Administration's role as it relates to the field of allergy is especially welcome. As you know, the Federal Food, Drug and Cosmetic Act was passed in 1938 and has provided modernized legislation dealing with foods, drugs, devices and cosmetics. This law provided for the first time Federal control of medical devices and cosmetics, as well as to extend the labeling provisions for food and drugs and particularly those dealing with special dietary foods and new drugs.

The principal responsibility of FDA is to provide consumer protection through enforcement of the federal laws which insure that foods, drugs, devices and cosmetics are wholesome and unadulterated. These articles must be safe to use, manufactured and distributed under sanitary and controlled conditions, and supplied with truthful and informative labeling. Through continuing enforcement activities by FDA, the public is assured of the quality of these regulated products and the manufacturers are protected against unfair competition from inferior or dishonestly labeled ones.

FDA was one of the first crime detection agencies in the government, since scientific methods have been employed to enforce the laws it administers for more than half a century. Potency of drugs and devices and purity of foods could not be measured without contemporary and forward-looking methods of analysis to maintain the standards of identity, quality and strength claimed for such articles. This is a major activity by the analysts associated with FDA, whose methods of analysis often are adopted by the industry and educational groups.

FDA is a relatively small governmental agency with a staff of about 1468 persons. It is headed by the Commissioner of Drugs with five technical and administrative bureaus with headquarters in Washington. There are inspectional and analytical staffs in our district offices in seventeen principal cities. There are also resident-inspector's stations throughout the United States. There are two scientific bureaus, namely, the Bureau of Medicine and the Bureau of Biological and Physical Sciences. The latter is comprised of the Divisions of Antibiotics, Cosmetics, Food, Microbiology, Nutrition, Pharmacology and Pharmaceutical Chemistry, all with professional and technical staffs.


## *The Author*

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### Foods

The allergist is especially concerned with the composition and production of foods consumed by his patients. In order to be most helpful in advising which foods his patients should avoid, the physician should recognize that all foods are not required by law to declare the names of all their ingredients on their labels.

Foods for which there are definitions and standards of identity are not required to designate the names of all the ingredients on the label. The required ingredients of such foods are named in the official standards. Even so, in certain food standards the regulations do require that optional ingredients be declared. When there is reason to believe that consumers are interested in the presence of a particular ingredient, it is customary to require a statement of its inclusion.

Among the foods which do not carry a list of ingredients on their labels because of exemption from this requirement pending the adoption of definition and standards of identity for them are certain canned fruits and canned vegetables for which standards have not been established, canned clams and canned fish roe, lemon extract, orange extract and vanilla extract, ice cream, frozen custard, ice milk, sherbets, and water ices, and non-alcoholic carbonated beverages. After September 17, 1959, all of the above except flavoring extracts and non-alcoholic beverages will have to carry a complete list of ingredients. Standards are pending for ice cream and the related frozen foods cited.

*Presented before an open meeting of the West Virginia State Society of Allergy, held during the 92nd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20, 1959.

Submitted to the Publication Committee, August 21, 1959.

For those foods for which no definitions and standards have been adopted, the labels must show the common or usual names of each ingredient if it is made from two or more constituents, except that spices, flavoring, and coloring other than those sold as such may be designated generically without naming each component.

Although food regulations are extensive and detailed, we do not know whether maximal help is being provided to persons suffering from food allergies. As physicians especially interested in this field, you are closely in touch with the needs of your patients and we would welcome your views in regard to this matter. One of our concerns currently is whether any appreciable number of persons are sensitive to the minute amounts of certain pesticides found in some foods. From information we have received, it would seem that sensitivity to pesticides is very rare. We are also following very closely the frequency and severity of reactions which occur from the presence of penicillin in milk.

Under the regulations for certification of penicillin and penicillin-containing drugs intended for treatment or prevention of mastitis in dairy animals by intramammary infusion, a single dose is limited to 100,000 units and the label clearly carries a warning that milk taken from penicillin-treated cattle should not be used for human consumption within 72 hours after the latest treatment for mastitis. FDA surveys since 1957 show a considerable reduction in penicillin in milk. If you encounter reactions which you suspect are due to penicillin in milk, the milk or milk product should be tested to determine whether penicillin, other antibiotics, or drugs are present.

### Food Additives

With the rapid technical developments in food processing and the desire of modern homemakers to have many foods available with little or no home preparation, it has become the manufacturer's purpose to include a variety of chemical ingredients to insure an economically desired shelf life for these products. The introduction of these special additives to foods brought a new section to the Act in 1958 to deal with the manufacturer's responsibility to insure that the added substances are safe for use. This is a relatively new development and the physician should be on the alert for any effects which can be clinically associated with the presence of such special additives. We welcome the views of experts qualified by scientific training and experience to evaluate the safety of food additives, and a period is allowed for their comment between the time a proposal is published and the final order issued.

### Drugs and Cosmetics

The Bureau of Medicine is most directly concerned with drugs and devices. The public health significance of the safe and effective use of these articles is readily apparent. Foremost among our responsibilities is the detailed review of new drug applications with respect to investigative clinical and experimental data dealing with safety of the drugs, as well as the control and methods of manufacture, in order to permit or deny their introduction into interstate commerce. It is a demanding and challenging obligation which requires the highest degree of sound medical judgment and awareness. As you readily appreciate, it is feasible to evaluate the investigative findings obtained by a few medical experts in carefully selected patients under controlled conditions, but quite difficult to foresee with absolute certainty what may arise when a drug is released for nationwide use, and perhaps used indiscriminately by some physicians or by the public if it is an over-the-counter item. Slightly more than 12,000 new drug applications, and many thousands of supplements to them, have been evaluated under the new drug provisions of the Act since 1938. It is estimated that up to 90 per cent of prescriptions being written currently are for drugs which have been introduced under the new drug provisions of the law.

Regulation of the labeling of all drugs and devices moving between states is a major activity of the Bureau of Medicine. In this connection, we encounter many difficult problems, some of them involving drugs and devices which are offered to remedy the allergic diseases; too often such products are distributed without rational therapeutic basis. Yet, in order to regulate these products we must be able to prove beyond reasonable doubt in a Federal Court of law that the article is misbranded or adulterated. This may require the cooperation of experts who are willing to undertake as a public service clinical trials with these products in order to demonstrate convincingly their worth or lack as therapeutic agents and to appear in court as expert witnesses.

### Certification Services

FDA conducts several pre-distribution certification services. Coal tar dyes used in foods, drugs and cosmetics must be from certified batches before sale in interstate commerce. Insulin and certain antibiotics, including penicillin, streptomycin and dihydrostreptomycin, bacitracin, tetracycline, chloramphenicol and chlortetracycline also are subject before distribution to certification procedures as to safety and efficacy. These health safeguards are mutually

recognized by the pharmaceutical industry and the Government.

### Misbrandings of Drugs and Devices

It is well recognized that unscrupulous vendors prey upon the sick with nostrums for all the ills of mankind. The sufferer of allergic diseases is all too often the subject of such health chicanery by the merchants of quackery. Hay fever and asthma often are held to be curable by promoters of illegally labeled products. I shall cite a few examples of flagrant disregard for truthful labeling which have been the bases of actions.

"Davis Formula No. 7895" consisting essentially of potassium iodide, an extract of a plant drug such as Lobelia, a small proportion of chloroform, sugar, alcohol and water together with a solution of Vitamin A containing 32,500 U. S. P. units per Gm. was offered as an adequate treatment for "asthma, both bronchial and spasmodic." FDA took legal action against the product for its grossly misleading therapeutic claims. The defendant entered a plea of guilty and was fined $500.00.

"Glanzyme No. 6" with a subdesignation "Asthmazyne" predicated its benefits on the presence of whole suprarenal 2 grains, Papain (Papaya-Enzyme) ½ grain, kelp 1½ grains, and alfalfa 4 grains to supplement glandular and enzymic functions to treat asthma adequately. The purveyor consented to a judgment of condemnation and destruction of the product. This merchandiser also had a series of other products for other diseases which were similarly confiscated.

William John Chittick trading as Chittick Biochemic Laboratories at Paris, Illinois, was criminally charged for the sale of "Asthmatic Solution," a colorless liquid containing 0.099 Gm. of methenamine per 10 cc., and iodides and phosphates of sodium and calcium. The purity and quality were below its represented use for intravenous administration since it was contaminated with undissolved material. Its use as an asthmatic aid was also improper. A plea of nolo contendere was entered and the court imposed a $250.00 fine and costs.

Vitamin-C 50 mg., Vitamin $B_1$, yeast and riboflavin shipped by the DePree Company, Holland, Michigan, constituted the "Wheatamin Brand Cevigards" offered for the symptoms of hay fever. The claimant failed to appear and the seized goods were destroyed.

Devices, too, frequently are offered for treatment of the allergic patient. Usually these cure-all gadgets are offered to rid the body of practically any pain or ache or disease. Hay fever, asthma and eczema are among the conditions claimed to be therapeutically benefitted. Heat lamps, units supplying radiant energies which cannot be measured, and other similarly bizarre units are all too often encountered.

Special dietary foods also are held out as adequate treatment for asthma and allied bronchial conditions. One such product was "Asmax," an organic formula containing Elmo Campone root, Yerba Santa, Dragon Turnip, Cubeb berries, Ipecac root, Horehound herb, White Pine compound, Irish Moss—to be used as a dietary supplement. This product was alleged also to clear affections of the air passages, spasms of the respiratory system, and conditions requiring respiratory ailments. Following legal action this "boon to man" was abandoned by the claimant and destroyed. The expert guidance of allergists has assisted FDA in handling some of these cases against valueless remedies offered for allergic patients.

A recital of many other such worthless cure-alls could be presented but the repetition only points up the need for truthfully labeled drugs and devices with adequate directions and warnings against unsafe use to inform and protect the user, whether he be physician or patient.

### Pilot Study

With the rapid introduction of new drugs, it is a major challenge to keep abreast of the untoward and adverse effects associated with the use of drugs. We need to know as quickly as possible about drug injuries or suspected reactions in order to safeguard other users. Too often we do not learn of such experiences until months have passed and the details essential to satisfactory interpretation no longer are available. This situation led recently to the setting up of a pilot study on "Reporting of Adverse Reactions to Drugs" with the Association of Medical Record Librarians in cooperation with the American Medical Association, the American Society of Hospital Pharmacists, and the pharmacy and therapeutics committees of eleven hospitals. The primary efforts of the study are directed toward study of methodology for selecting, reporting, coding, evaluating and disseminating such data. This may point the way to an extensive program of reporting unusual responses to drugs and other products.

Your professional practice brings you cases of untoward responses to drugs and cosmetics which would be helpfully revealing if made known to us. Based on a single report, not much in the way of control is possible, but a series of similar reports would serve to bring

about a ready basis for correction of the deficiency. This is particularly significant in relation to the treatment of patients with a history of an allergic condition since the physician must weigh the hazards involved with his therapeutic regimen against the nature and extent of the disease under treatment.

The study of mechanisms of untoward effects of therapy is also closely allied to the field of allergy. Not infrequently the ascribed basis is predicated on an allergic phenomenon. With intensive interest and study, a great contribution can be made in the determination of the causative factors and the immune processes involved so as to serve in avoiding reactions.

### Cosmetics

Cosmetics must not be dangerous to users. The cosmetic provisions of the law do not require the listing of ingredients on the label, but if they are listed they must be accurately designated. As a safeguard to users, patch testing directions are required on the label of coal tar hair dyes, with a warning that the product contains ingredients that may cause skin irritation on certain individuals. This practice, unfortunately, is not always followed and major reactions continue to occur. FDA, through its investigations of reported cosmetic injuries, has found that an overwhelming proportion develop by reason of allergic reactions. The frequency of reactions seen among users of cosmetics makes it evident that we should learn as much as we can with respect to offending ingredients so as to protect users from highly sensitizing substances. Your clinical experience and judgment as allergists are fundamental to the resolution of such problems.

I am confident you know of the injuries created by the application of Ten Day Press-on nail polish. This ready-made method of applying finger nail polish led to serious and painful delamination, splitting and breaking off of the nails. FDA proceeded against the sale of these cosmetic aids and they were withdrawn from the market. Through prompt and decisive action, women all over the country were spared from further ill effects of this agent.

### Research

In order to enforce the varied provisions of the statutes administered by FDA, a wide range of research activities is necessary. The development of analytical or biological methods of identifying and measuring normal and, when contaminated, the abnormal, constituents of foods, drugs and cosmetics is a continuing program. Acute and chronic toxicity studies in laboratory animals provide essential information relating to the safety of many ingredients used or proposed for foods, drugs and cosmetics. Studies to determine the nutritive value of food and the effects on nutrition of food additives are continuously in progress. Clinical investigations of drugs and devices in order to establish their therapeutic benefits are necessary to secure convincing evidence for presentation in Federal court when false and misleading curative claims are alleged. Special surveys are conducted to obtain consumer understanding of the labeling representations made for the various classes of regulated products. Microbiological research is in progress for the purpose of detection, prevention and control of food poisoning and for that of improving the sanitary quality of foods.

From this general and perhaps too rapid review, it becomes evident that we share a mutual interest in the protection of your patient's health as well as the public health through maintaining active vigilance over the nation's supply of foods, drugs, devices and cosmetics, caustics and corrosives. Only with your public spirited cooperation can we fulfill our responsibilities in this challenging and rewarding endeavor.

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## Mental Patients and General Hospitals

The development of new treatment techniques, especially the tranquilizing drugs, broader insurance coverage for psychiatric disorders, and more private practicing psychiatrists have increased the demand for admission of mental patients to general hospitals. Yet more than half of the general hospitals in the United States never admit a known psychiatric patient, one-third admit such patients solely for diagnosis or for emergency treatment, and only 1 per cent have a psychiatric service even though mental illness is America's number one medical problem.—Frank J. Ayd, Jr., M. D., in Journal, Michigan State Medical Society.

# Headaches as Related to Allergy*

*J. Warrick Thomas, M. D.*

HEADACHE is a very common symptom and in many instances it may be a major problem to the patient. Since headaches may be due to a variety of causes and certain patients may exhibit more than one type of headache, a comprehensive diagnostic study and consideration of the headache patient is warranted. One must not only determine the cause of the headache and its differentiation, but the relation to multiple disease entities must be appreciated and properly allocated in the therapeutic program.

Ogden[9] made a study of 4,634 persons, representing a cross section of population. The study was arranged so as to indicate the background allergic factors of the patients with headache as compared with those without. He reported that previous studies of this type had been limited primarily to patients with headache, none having been conducted on the basis of the general population. One noteworthy finding was that recurrent headache is present in over 60 per cent of the general population. Migraine, as broadly defined, was found in 13.2 per cent of persons with headache, whereas in its rigid definition it was found in only 5.2 per cent. Histamine cephalgia, strictly defined, was found to be a clinical rarity. Recurrent nasal symptoms were reported by 45 per cent of those with headache as contrasted with 19 per cent of those without. Of the number who complained of headache, 92 per cent gave a history of symptoms of a so-called "cold," and it is possible that in many cases the symptoms might have been manifestations of respiratory allergy. Of the non-headache group, 11 per cent gave a family history of allergy, whereas, the headache sufferers reported a 25 per cent family history of allergy.

### Classification

Because headache so often is found to be a symptom of some other disease, it is difficult at times to think of it as a separate entity. In general, however, in this presentation, I shall classify headache under two broad headings: *allergic and non-allergic.*

(1).—*Allergic Headache.*—The allergic headache, or true migraine, frequently occurs intermittently. It may be unilateral at onset, later becoming generalized, accompanied by or preceded by cortical or visual sensory disturbances and, later, ending in nausea and vomiting. Often there is a family history of migraine or other allergic manifestations.

Rowe[11] suggests that migraine may be divided into four stages; (1) the prodromal, (2) the aural, (3) the culminative and (4) the post-migrainous. The symptoms of migraine are quite variable and are summarized, as follows: premonitory hyperactivity, or irritability, or depression; disturbed or blurred vision; emotional imbalance; yawning; insomnia; profound sleep; fatigue; bad breath; canker sores; abnormal appetite; nausea; vomiting; constipation; indigestion; body aching; stretching; chilliness.

The attack may progress with pronounced visceral and vasomotor symptoms involving the cranial or peripheral nerves. These pains may vary in intensity as well as location. There may be nausea and vomiting of varying degrees of severity and duration, from a few minutes to several hours. The residual symptoms include general malaise, drowsiness, anorexia, polyuria, rhinorrhea and varying degrees of exhaustion. These patients also may have other associated symptoms which have been described by many authors and which include transient psychoses, emotional upset, ocular palsy, neuralgia, paroxysmal tachycardia and epilepsy. A number of reports[12, 16, 17] have been published of migraine cases in which definite allergic factors have been found and their control resulted from the elimination of food and inhalants[15] and the injection of specific allergens.

The age incidence of the migrainous type of headache is similar to that of other allergies, occuring usually in the second, third or four decade of life, although migraine may occur


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***Presented before the annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology at The Greenbrier in White Sulphur Springs, June 9, 1959.**

**Submitted to the Publication Committee, August 28, 1959.**

also in children,[10] and is manifested by cyclic vomiting.

(2)—*Headache Secondary to Nasal Allergy.* This headache is sometimes called "sinus headache" resulting from nasal or upper respiratory tract allergy, and it usually is secondary to nasal obstruction. It is not so characteristic as migraine and may lack definite symptomatology and periodicity. The usual location of the headache is just above the eyes in the region of the frontal sinuses. It may be characterized by a dull to sharp pain or discomfort. It often is preceded or accompanied by pain or tightness at the bridge of the nose, due to the intense swelling of the middle or upper turbinates. This congestion, in addition to the discomfort from the pressure, also interferes with the proper aeration and drainage of the sinuses.

(3).—*The Vacuum or Frontal Type of Headache.* This type results presumably from an obstruction of the nasal frontal duct with absorption of air, swelling of the mucosa and transudation of fluid into the sinus cavity. There may be some disagreement about the cause or existence of the vacuum of frontal headache; however, one observes that the discomfort or pain promptly disappears with the shrinking of the mucosal membranes of the turbinates by any form of treatment, i. e., management of nasal allergy or the use of drugs designed for the relief of nasal stuffiness, either topically or orally, as observed in antihistaminic therapy.

(4)—*Non-Allergic Headaches.* I will comment on the non-allergic headaches only for the purpose of grouping them under general headings, which will serve as a partial outline to contrast them with the allergic or migraine type:

A. Headache associated with cardiovascular disease
B. Neurologic headache including neoplasm, meningitis and epilepsy
C. Headache secondary to eye strain and other eye conditions such as glaucoma or refractive error
D. Headache related to or resulting from bacterial infections of multiple types. Headache of syphilitic origin belongs here
E. Headache associated with arthritis or degenerative joint changes
F. Headache of psychogenic origin as well as that coincident with spasm of the skeletal muscles and vasometer changes including tension headache
G. Miscellaneous headaches of undetermined origin, including physiological and endocrine disturbances
H. Histamine cephalgia warrants consideration separately. It is a syndrome, with the following clinical characteristics:
   a. Absence of a family history of sick headache or allergic disease
   b. Onset most common in 4th or 5th decade
   c. Short duration, frequently less than one hour, beginning and ending sharply
   d. Hemicrania, usually severe pain which may be constant, excruciating, burning, boring (suicide frequently contemplated)
   e. Usually occurs at night (during sleep), clockwork regularity, frequent
   f. Eased by sitting up or standing erect
   g. Associated with vasomotor phenomena consisting of lacrimation, congestion of the eye on the involved side, rhinorrhea or stuffiness of the nostril, increased surface temperature, oftentimes swelling of the temporal vessels of the involved side of the head
   h. Attacks are frequent, as often as 20 times a week
   i. Compression of the common carotid artery and sometimes the temporal arteries, early in an attack, frequently gives prompt relief
   j. Occasional nausea, no vomiting
   k. No aura
   l. No relation to menstrual period
   m. Alcoholic beverages frequently precipitate attacks
   n. Histamine 0.1 mg. to 1.2 mg. subcutaneously usually will precipitate an attack of unilateral pain identical to the spontaneous attack
   o. Adrenalin 1:400,000 solution intravenously gives prompt relief
   p. Cure by hyposensitization to histamine

Horton,[5] in a study of 184 patients complaining of headaches, found that 72, or 40 per cent, had a histamine cephalgia. Of the 72 patients, 63 per cent were desensitized to histamine. Forty-eight of the 72 had complete relief for varied periods of time.

**Pathology and Physiology**

The definite pathology of migraine as well as that of other similar headaches is as yet unknown, although there are many theories. Goltman[4] studied a patient with a burr opening of the skull, in the left frontal area, which had been made because of a suspicion of brain tumor. During the intervals between attacks of migraine, the opening in the skull was depressed, but during an attack there was a marked bulging in this area. In this particular case the migraine and bulging of the operative site could be reproduced at will by the patent's ingestion of wheat.

Friedman and Van Storch,[3] after a number of years' observation, reported that in the great majority of cases, headache has a strong vascular component. They observed that the initial phase of vasoconstriction is responsible for the prodromal symptoms, while the pain follows marked distention of the cranial vessels which are temporarily hypotonic. Studies[14] were made of the extracranial arterial pulses, and it was concluded that after an initial non-painful vasoconstrictive phase early in the course of the headache, there was progressive dilatation in the relevant vascular bed. Other studies have indicated that there may be an altered reaction in the electrolyte balance occurring in association with headaches.

In those patients with symptoms such as might be observed in a patient with Meniere's syndrome, it is thought that the symptoms result from a local disturbance of the inner ear. The causative factor is the local alteration in the permeability of the capillary wall of the labyrinth resulting in local edema.[6] Dale proposed several years ago that histamine is released when the particular foreign substance to which man or animal is hypersensitive comes in contact with a specific antibody in the tissues. Histamine in turn causes smooth muscle spasm and localized edema, which are the lesions of anaphylaxis and allergy.[1]

According to Best and Taylor,[2] pain in the ordinary type of headache is of intercranial origin, beginning in the vessels of the pia mater and locality and in the larger vessels of the dura mater, all of which are sensitive to pain resulting from dilation of the vessels and excitation of sensitive nerve endings on the vessel walls or in the vicinity.

#### Etiologic Considerations and Investigation

In the investigation of the patient with severe migraine or similar type of headache, it is necessary that a careful and detailed history be taken before outlining any program of study. Regarding the history, we must question the patient along the line of the possible etiological factors which include foods, pollens, seasonal factors, odors and foci of infection, and whether the headaches are influenced by weather conditions such as humidity, or by nasal obstruction, sinusitis, and emotional components. It also is desirable to ask the patient to describe a typical attack.

The patient should be questioned regarding the location of the headaches, whether right side, left side, or bilateral; are they usually one-sided or bilateral; if one-sided, which side? In further localizing the pain, determine whether it is in the front, the back or the top of the head, and obtain a description of the character of the pain and in what manner it varies—is it sharp or dull? Is it a pulsating, pounding or piercing type of pain? Determine whether the patient has any difficulty in talking during the attack and whether or not there is mental confusion. Is there associated numbness, tingling or pain in the fingers, hands, feet, lips, nose, or any other organ? Were symptoms of temporary weakness or paralysis of any of the muscles ever observed during an attack? Has any other person noted a flushing or paleness or sweating on either side of the patient's face?

It is wise to have the patient list the symptoms in regard to time and relation of the attack and whether these symptoms accompany all attacks or are present only at times. Obtain such details that may be of importance. Do the arteries of the temporal area get quite hard and cord-like early in the attack and, if so, which location? What aura or symptoms are recognized as preceding or giving evidence of the onset of attacks, such as blurring of vision, spots or the flashing of lights before the eyes, the craving of sweets, canker sores, hives, dizziness, photophobia, urinary frequency, indigestion or constipation. Ocular symptoms such as blurring of vision, spots before the eyes, flashing of lights, double vision, blindness, one-sided blindness, and temporary paralysis of eye muscles should be described in detail. Observe which eye is more frequently involved. Is there evidence of mental confusion or memory impairment on onset or during the attack?

Describe the frequency of the attacks as well as the duration, also whether there is any regularity or specific occurrence, such as a certain day of the week, weekends or once a month. Is there any regularity or suspect for the cause of the attack? What per cent of the attacks, roughly, are accompanied by nausea, vomiting or diarrhea? Are symptoms of indigestion, nausea, vomiting, pain or diarrhea present at other times similar to those symptoms when headache is present? Are there any known contributing or aggravating causes of the attacks such as specific foods, including candy, starches, seafoods, meats and condiments?

If possible, determine just what measures the patient takes to treat a specific attack. These would include drugs, local applications, going to bed or to sleep, the use of a heat lamp, and whether it is necessary for a physician to be called for a specific type of therapy. Are there some drugs that relieve at one time and other drugs at another?

Insofar as possible, one should determine the date of the initial attack, whether there have been long periods of freedom between the attacks and whether the attacks have gotten progressively worse, or if there are other variables.

In addition to the above questions, there may be other information regarding endocrine components, such as menstrual periods, pregnancy, hospitalization, vacation or geographic changes relating to the headaches. A careful determination of the family history of headaches including not only the parents, grandparents, brothers and sisters, but the aunts, uncles and great-grandparents is helpful. Occasionally one might find several generations in which headache or mi-

graine has been a factor. It is also desirable to elicit any other associated history of other manifestations of allergy such as asthma, hay fever, hives, eczema, epilepsy and food reaction, either in the patient or in his family.

I make it a practice in handling these patients to supply the patient with a so-called "migraine questionnaire," attempting to obtain all of the above information supplemental to a routine allergy history. In this way the recording of such data is simplified.

After obtaining a detailed history, we outline a program of investigation which may include routine and special laboratory studies, such as roentgenograms, examination of thyroid function, sensitivity studies with various foods, inhalants, bacteria, molds and pollens. Autogenous vaccines are prepared from any possible or potential foci of infection. The type and extent of sensitization studies depend upon the presence of other allergic manifestations. In investigating and studying these patients with an allergy, we endeavor to control, insofar as possible, other various allergic manifestations if they are all interrelated, as it is essential to lessen the allergic overload. All allergic manifestations should be controlled insofar as possible.

In many of these patients the problems are multiplied; many are questionable and may relate to other branches of medicine, in which cases we have found it wise to refer the patients to specialists in the indicated fields. For example, in endocrinology, dentistry, internal medicine, ophthalmology, otolaryngology, neurosurgery, psychiatry, neurology or orthopedic surgery, we have to evaluate the recommendations resulting from such consultations, weighing carefully the opinions presented and, finally, correlating all the data that we have in such a manner that the patient may be placed on a program of treatment that may offer him control or, at least partial relief of his distress.

**Treatment**

A. *Symptomatic:*

1. Ergotamine derivatives. Ergotamine tartrate and its derivatives and combinations[8] such as Gynergen (ergotamine tartrate), DHE-45 (dihydroergotamine methane-sulfonate), Cafergot (ergotamine tartrate and caffeine), Cafergot PB (ergotamine tartrate and caffeine, with belladonna alkaloids and pentobarbital sodium) and Wigraine (ergotamine tartrate and caffeine with belladonna alkaloids and acetophenetidin) have been especially useful since they specifically constrict cranial blood vessels. Ergotamine tartrate parenterally usually is effective in a dose of 0.5 cc. (0.25 mg.); not more than 2 cc. should be used in any one week.

In some patients DHE-45 is better tolerated. The dose is 1 cc. (1 mg.) intramuscularly or intravenously. Some patients require a larger dose but usually not more than 3 cc. should be administered in any one week. Ergomar 2 mg. (Nardson) sublingual tablets are rapidly absorbed under the tongue in about 30 seconds, and the cerebral vasoconstrictor effects are apparent in 10-15 minutes. The dosage is 1 tablet every half-hour until relief is obtained, not to exceed 3 in 24 hours. Hydergine (Sandoz) 0.5 Gm. sublingual tablets (hydrogenated ergot alkaloids) produces vascular dilatation with improved peripheral blood flow, lowers systemic blood pressure and slows the heart rate. Bellergal tablets (ergotamine tartrate, bellafoline and phenobarbital) have a stabilizing effect on the function of the autonomic nervous system. The dosage is 1 tablet q. i. d., with weekly dosage reduction. (Bellergal tablets 1 b. i. d. are a more recent form of this drug combination.)

2. Other sympatholytic drugs such as amphetamine compounds and vitamins are said to be helpful.

3. Epinephrine hydrochloride aqueous 1:1000 (Adrenalin-minims 5-15).

4. Coal tar derivatives (acetanilid, phenacetin or aspirin). At times these may be given in combination with caffeine, such as is seen in CAP tablets.

5. Sedative drugs such as barbituric acid derivatives, including phenobarbital and hyoscyamine sulphate in combination are beneficial. This group of drugs may be given either orally, intramuscularly or as suppositories.

6. Psychotherapeutic drugs, particularly those that are a central muscle relaxant and sedative, including Meprobamate (Equanil) and others.

The central sympathetic suppressants are phenothiazine derivatives and include drugs such as Thorazine, Trilafon, Compazine and Sparine. Central sympathetic suppressants or rauwolfia derivatives are of help in some instances; the drying effect of these drugs, however, is sometimes annoying to the patient.

7. Antihistamines particularly are of value in those instances in which headaches are secondary to nasal congestion.

8. Steroid or endocrine therapy may be of value. This includes the use of injections of pituitrin as well as the use of cortisone deriva-

tives such as Prednisone, Prednisolone and Medrol, particularly in instances of marked nasal congestion, with secondary headaches.

9. Gastric lavage.

10. The improvement of living habits ought to be considered an important aspect in the therapy of migraine patients. This includes adequate personal, physical and emotional hygiene, and the avoidance of fatigue and emotional upsets.

11. Either cold or hot applications to the head may offer some relief.

12. Narcotics (codeine, morphine, dilaudid and demerol) may be considered for extreme pain.

13. Oxygen by inhalation.

14. The use of ammonia and potassium forms of carboxyllic ion exchange resin is recommended by Klingman,[7] along with a diet restricted to 1,000 mg. daily of sodium for a period of 10 days.

B. *Therapeutic or Curative Treatment:*

1. Elimination of allergens, known and suspected
   (a) inhalants
   (b) ingestants, including foods, and the use of a food-diary, as well as the elimination of ingested drugs
2. Hyposensitization with inhalant extracts
3. Autogenous vaccines and non-specific therapy
4. Digestive aids.
   (a) dilute hydrochloric acid
   (b) bile salts
   (c) pancreatic enzymes
5. Surgical treatment
   (a) removal of foci of infection (teeth, gallbladder, tonsils)
   (b) sympathetic ganglionectomy
6. General measures
   (a) control of nervous factors, adequate rest, diet and vitamin intake
   (b) use of glandular extracts, including thyroid
7. Histamine hyposensitization


**Summary**

Headaches are classified as allergic and non-allergic. The etiology and symptomatology of the allergic headache are discussed. Non-allergic headaches are grouped for the purpose of classification and differential diagnosis from the standpoint of etiology and associated clinical manifestations.

Allergic migraine has been postulated as a reaction to an allergen, usually a food, although inhalants and drugs have been incriminated. These headaches are recurrent, may be unilateral, are accompanied by visual and gastrointestinal disturbances, and by pain of varying intensity. The attacks are not infrequently preceded by an "aura," and if treatment is instituted early, the severe symptoms may be aborted.

Those headaches secondary to nasal obstruction, such as seen in allergic rhinitis, which may be the so-called "sinus," "vacuum," or "frontal" headaches, are relieved by shrinking the nasal mucous membranes. Adequate allergy management is indicated.

Recurrence of headaches following exposure to offending antigens, and the presence of other coexistent allergic manifestations often confirm the diagnosis of an allergic type of migraine headache.[13]

The treatment of migraine has been divided into two general divisions: (1) symptomatic and (2) therapeutic or curative.


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• **minimal disturbanc** of the patient's chemical and psych balance[1,4-18]

*At the recommended antiallergic and anti-inflammatory dosage levels, ARISTOCORT means:*

- **freedom from salt and water retention**
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Diacetate Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

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# Panel on Repository Pollen Therapy*

*Moderator: Merle S. Scherr, M. D., Charleston, W. Va.*

### Introduction

*The Moderator*

We are proud to announce today, at this Second Annual Meeting of the West Virginia State Society of Allergy, that we have on our program a panel consisting of four distinguished allergists with much interest and experience in a relatively new method of treatment in the field of allergy: the repository pollen therapy or, as it is commonly called, "the one shot method of treatment."

Since the method has had much publicity both in lay and medical publications, I feel that it would be of special interest to all of us to hear these men discuss their experiences and impressions with regard to repository pollen therapy.

We are pleased to have on our program today the following outstanding allergists: Dr. Macy I. Levine, Assistant Professor of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania; Dr. Mayer A. Green, Instructor in Allergy, Department of Dermatology, University of Pittsburgh School of Medicine; Dr. Philip Blank, Instructor in Allergy, University of Pittsburgh School of Medicine; and Dr. Howard G. Rapaport, Associate Professor of Clinical Pediatric Allergy, Albert Einstein College of Medicine, New York City.

Doctor Levine will introduce the subject, and will be followed by Doctor Green who will discuss the indications, restrictions and some of the problems met with in this type of therapy. Doctor Blank will then discuss his experience with the method in a group of patients, most of whom were adults. We shall hear next from Doctor Rapaport who, with his colleague, Dr. Sidney J. Appel, conducted a pilot study of the method's use in children, in a small series of selected cases.

This is the first time that the subject of repository pollen therapy has been presented at a state medical meeting. Time alone will tell its exact place in the management of pollen allergies. At present, experiments are being conducted also with substances other than pollens, i.e., molds, house dust, influenza vaccine, and the like.

Whereas the present method appears quite promising, it is only by its extensive application, with objective evaluation of results, that the final answer regarding its usefulness will be made known.

*Sponsored by the West Virginia Society of Allergy and held Thursday, August 20, 1959, during the 92nd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs.

### *Panelists*

- **Macy I. Levine, M. D., Assistant Professor of Medicine, University of Pittsburgh School of Medicine, Pittsburgh.**
- **Mayer A. Green, M. D., Clinical Assistant Professor, Allergy Section, Department of Dermatology, University of Pittsburgh School of Medicine, Pittsburgh.**
- **Philip Blank, M. D., Instructor in Allergy, University of Pittsburgh School of Medicine, Pittsburgh.**
- **Howard G. Rapaport, M. D., Associate Professor of Clinical Pediatric Allergy, Albert Einstein College of Medicine, New York City.**

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### Background of Repository Therapy

*Macy I. Levine, M. D.*

Recent developments in the use of pollen antigens in emulsion form have aroused hopes of a great advance in the management of the allergic patient. Let us briefly review the background of emulsion, or repository, therapy and discuss the theoretical basis for its use.

Noon, of England, first reported, in 1911, the successful use of pollen extracts in the treatment of seasonal allergic rhinitis. Since then, allergists have continued the search for better methods of hyposensitization, aiming to improve the results of therapy and at the same time to reduce the number of injections and the frequency of visits to the physician. Various workers incorporated pollen extracts in olive oil, almond oil, sesame oil, lanolin and gelatin, but because of local or systemic reactions, or technical problems, the results were not satisfactory. Freund and McDermott, in 1942, reported that the combination of certain antigens with an adjuvant consisting of mineral oil, tubercle

bacilli and an emulsifying agent produced a heightened and prolonged antibody response in experimental animals. Not long afterwards, Loveless began to use pollen antigens with an adjuvant in patients with seasonal pollinosis. Her adjuvant included mineral oil and an emulsifying agent, *without* the tubercle bacilli. She found that many times the usual pollen dosage could be administered at one sitting with reasonable safety and with encouraging therapeutic results. With only a few such injections patients could be adequately protected against their seasonal symptoms. Since 1947, Loveless has extended her own observations, and the technique has been improved so that only one injection need be given before the season. More recently, other workers have used this mode of therapy but the clinical effectiveness, incidence of reactions, and selection of cases require further evaluation. Subsequent panelists will elaborate on the technique and results of treatment.

Although the exact mechanism by which pollen therapy exerts its benefit is not clear, one current theory holds that improvement in the patient occurs through the production of a blocking antibody which preferentially binds the specific antigen and blocks the usual antigen-antibody reaction that results in the production of allergic symptoms. So far the use of emulsions has not advanced our knowledge of the allergic mechanism. It is believed that when emulsions, properly prepared, are used, the antigen is present in very small globules, entirely coated with mineral oil. Following subcutaneous administration, the antigen is slowly released over a prolonged period of time, providing a sustained antigenic stimulus with the development of an increased titer of blocking antibody. Immunologic studies are now in progress to test this hypothesis. It is hoped that this technique will provide us with new information about the allergic process, as well as contribute an improved method in allergic management.

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## Indications, Restrictions and Problems In This Type of Therapy

*Mayer A. Green, M. D.*

Repository pollen therapy represents an evolutionary rather than a revolutionary approach in the management of hay fever by the injection technique. For many years, various workers in allergy have experimented with the use of pollen extract in several media such as oils and gelatins in their attempt to delay and prolong pollen absorption from the injected site. Their objective was to obtain a superior antibody response with fewer injections than was possible with the use of aqueous pollen extracts. Each of the methods was given a clinical trial, with subsequent abandonment of the procedure for many reasons, some of which are as follows: instability of the vehicles, excessive local and general reactions, susceptibility of the material to contamination, abscess formation at the injected site, excessive pain on administration, and the capacity of sensitization by the vehicle itself.

Interest in the procedure lagged until Freund's observation of improved antibody response using adjuvant with antigen. This was followed by the pioneering and persevering efforts of Loveless with 100 ragweed hay fever subjects who volunteered to accept repository doses of pollen. Loveless adhered to a ritualistic procedure which involved ophthalmic and skin testing with serial dilutions of antigen in order to establish the optimal protective dose. Her annual reports of response, although encouraging from the viewpoint of beneficial results, were punctuated by accounts of the development of unpleasant local and systemic reactions of varying degree. As a result, this technique remained more or less limited to experimental use by Loveless.

In the past few years, Brown, of Boston has lent impetus to the method by careful and extensive work on thousands of hay fever patients. In his hands, and with progressive improvement in the emulsifying agents used to carry the antigen, he has demonstrated the feasibility of administration of single, slowly released, emulsified doses of pollen antigen. His reported results in hay fever are equal if not superior to, those obtained with aqueous pollen extracts. Several other investigators, following the Brown or the Loveless technique, likewise now are reporting favorable results when the procedure is meticulously followed.

Apparently, patients in a certain category will be eminently suited for this type of therapy, as follows: hay fever patients who will not or cannot report for multivisit therapy with aqueous antigens, and uncomplicated pollen cases. The method will not suffice for complicated allergic problems.

In its present form, use of the method will have to be restricted to allergists skilled in the preparation and administration of emulsified antigen. The importance of this is readily apparent when it is realized that any unemulsified extract may produce a constitutional reaction of alarming and, possibly, fatal nature. Technical and mechanical considerations complicate

the procedure. Long-term appraisal will await the passing of time.

Meanwhile, the time honored and proven technique of hyposensitization with aqueous extracts will remain the method of choice for most physicians and hay fever patients.

Repository therapy makes available another modality for selected hay fever patients in the hands of highly qualified allergists.

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## Repository Therapy Experience In a Group of Patients

*Philip Blank, M. D.*

The single visit therapy of pollinosis with emulsions recently has attracted much attention and comment. The discussion of this panel is merely a review of the more salient points as to history, preparation of emulsions and results of therapy to date. Our own results and experience form the basis of the comments by the various panelists.

The purpose of this form of therapy of pollinosis is to give a single treatment per season. Repository antigen is administered as an emulsion. It should, of course, have no deleterious effect.

The underlying principle of the method is not new. As far back as 1923, Sutton[1] attempted to achieve this end by using olive oil and undried pollen. Naterman,[2] a few years later, employed lanolin and olive oil with ragweed extract and demonstrated the slow absorption and the more prolonged action of these products. Freund and McDermott,[3] in 1942 showed that the addition of an adjuvant such as mineral oil to an antigen enhances antibody formation. Thus, the principles of slow absorption and enhancement of antibody formation have been definitely established through the years.

Brown and Loveless have done outstanding work in developing these ideas into definite clinical procedures. A list of the writings of these tireless investigators has not been included in this discussion.

From a clinical viewpoint the following are the problems involved in this type of therapy:

1. Preparation of emulsion.
2. Technique of administration.
3. Determination of dose.
4. Evaluation of results.
5. Side-effects.

### Preparation of Emulsion

Drakeol and Arlacel A are used as the oil and the emulsifying agent. They are mixed in the proportion of 9:1 (Drakeol 9 cc. and Arlacel A 1 cc.) To this mixture is added aqueous pollen extract, adrenalin 1:100 and normal saline. The formula of the mixture is as follows: To 2 cc. of the mixture of Arlacel A and Drakeol is added 1 cc. of aqueous pollen extract, 0.4 cc. of adrenalin 1:100 and 0.6 cc. of normal saline. The dosage of pollen extract in this 4 cc. mixture is four times the dosage desired for treatment since 1 cc. of emulsion per dose is administered. Thus, 40,000 PNU per cc. is used in the 4 cc. mixture before emulsification. The dose of emulsion is then 10,000 PNU per cc. If the dose of 5,000 PNU is wanted, then 1 cc. of 20,000 PNU per cc. extract is used in the mixture. This method follows Brown's technique.

The emulsification of the preparation is of utmost importance. In this process, the water and oil are dispersed so as to form a homogenous mixture, of which there is neither free oil (oil phase) nor free water (aqueous phase). Emulsification is established by turbulence. Various methods have been devised to accomplish this. The mixture (4 cc. described above) is emulsified in a closed system under aseptic conditions by passing, under pressure, the material from one 10 cc. luer lock syringe into another through a double hub 18 gauge needle for the minimum of 40 strokes. This may be done by hand or machine. Other methods have been described.

It is extremely important that the mixture be completely emulsified since an excess aqueous phase means the quick absorption of pollen extract, with the possibility of constitutional reaction. There are many tests to determine emulsification but as yet no standard test has been devised. Some of the tests used clinically are noted: The emulsion should not yield a positive skin reaction on scratch test; a drop of emulsion floats in cold water as a distinct sphere, and should present an even and diffuse appearance on microscopic examination.

Warning must be given that emulsions are not stable under all conditions. They distinctly are not stable in the presence of glycerine and alcohol. Thus, glycerinated extracts cannot be used. Alcohol cannot be used in the preparation of the injection site.

Preparing or administering this type of emulsion should not be attempted without some basic knowledge of emulsion chemistry.

### Technique of Administration

The dose of emulsion is 1 cc. given in a dry tuberculin type syringe with a dry 25 gauge ⅝ inch disposable needle. No preparation of the site is needed. The emulsion usually is given in three equally divided doses approximately 15

minutes apart. The needle is introduced into exactly the same area until the entire 1 cc. has been administered. After each injection the patient applies pressure to the injection site.

Pre-injection and post-injection medication have been used. Pre-injection medication may include Susphren proximal to the area of injection and the oral use of antihistaminics. Post-injection medication may include steroids, antihistaminics and ephedrine products. These measures are purely precautionary.

### Determining the Dose

No satisfactory method of determining the dose required for each patient has as yet been found. Perhaps this may not be necessary; perhaps in all cases the same dose may be used. Many methods have been devised, some outright guesses, others a little more pseudoscientific. Loveless estimates the dose by eye tests and Brown evaluates the dose by a puncture scratch test. I am not sure that a good clinician with some experience can do as well simply from the history of the severity of the case. We have used the following schedule:

Scratch test positive to 10 PNU* receives 1,500 PNU.
Scratch test negative to 10 PNU but positive to 40 PNU receives 2,500 PNU.
Scratch test negative to 40 PNU but positive to 160 PNU receives 5,000 PNU.
Scratch test negative to 160 PNU but positive to 640 PNU receives 7,500 PNU.
Scratch test negative to 640 PNU but positive to 2,540 PNU receives 10,000 PNU.

Injections should be administered 4 to 6 weeks prior to the pollen season.

### Evaluation of Results

Evaluation of results is very difficult and especially so since no definite criteria for improvement have been established. The patient's history is difficult to interpret. He may say he had no hay fever, he only wheezed a little or he may complain bitterly because he had a paroxysm of sneezing 2 hours before he visited the physician. His written report on a daily tabulation also is difficult to evaluate. We used the following classification to express the degree of relief: The patient who had satisfactory relief and did not require medication was expressed as marked relief. One who had satisfactory relief but did require occasional medication was expressed as moderate relief and, finally, one who had unsatisfactory relief even with ordinary medication and whose control was similar to untreated cases was expressed as no relief.

Since, at the time of the panel and at the time of preparation of this paper, the statistics had not been fully evaluated, I am presenting only my impression. The results seem to be as good, if not a little better, than those in routine multivisit, non-emulsion treated cases. A complete resume of the results will be presented at a future date.[4]

It is felt that this method of therapy is feasible and relatively safe in experienced hands. The procedure, however, is not without danger. We have encountered three constitutional reactions, none of which presented undue problems in control. This number of reactions does not represent a much greater hazard than that ordinarily noted in the same number of cases in which treatment is by routine high dosage multivisit therapy.

Evaluation of results, however, is not only a clinical experience but also an immunological and chemical study. In our investigation, antibody titers, blocking antibody titers and hemagglutination and other studies are being attempted. Many more cases, however, must be evaluated under uniform conditions before any assessment can be of biostatistical significance.

### Side-Effects

Various side-effects have been described. Mild to moderate local reactions have been described. Abscesses have been described. In our experience, mild local reactions were not recorded. No serious local reaction was induced, nor was induration or abscess formation noted.

As previously stated, however, three constitutional reactions were noted by us. Evaluation is difficult. Nothing yet is known of the long-term effect of the oil and emulsifying agent. Neither Brown nor Loveless, however, has recognized any, if such occur.

### Comments and Summary

The repository therapy of pollinosis with emulsions seems to be safe, practical and efficacious in proper hands.

Much remains to be discovered concerning this form of therapy; in fact, much remains to be discovered about pollinosis. If the only result of the tremendous impact of discussion of this type of therapy is to stimulate the study of the treatment of hay fever, then we may say "Well done."

Many basic problems are again receiving the scientific stare. What is the role of antibodies, of blocking antibodies? Why do hay fever patients get better with specific therapy? Or do they? With the help of clinicians, immunologists, biochemists, pathologists, biostatisticians and, perhaps, you and me, some of these questions and many others will be answered.

*Protein Nitrogen Units.

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## Pilot Study in a Group Of Pediatric Patients

*Howard G. Rapaport, M. D.*

I thank Dr. Merle S. Scherr of the West Virginia State Society of Allergy for having been kind enough to invite me to participate in this panel discussion on repository pollen treatment.

Of course, all of you are familiar with the fact that the present day accepted treatment of pollinosis, while productive of satisfactory results in the majority of instances, is both time consuming and costly. Any procedure which could be used safely in the treatment of pollinosis in children and which would reduce the number of patient visits to the doctor as well as the cost involved and still produce comparable results, would be a significant step forward.

With these goals in mind, in June, 1959, my associate, Dr. Sidney J. Appel, and I, have selected from our Pediatric Allergy Clinic at the Bronx Municipal Hospital Center, a small group of children ranging in age from six to thirteen years. All of these children previously had had the conventional multiple injection hyposensitization for ragweed pollen during at least one season, and many for two.

All the children received the prophylactic preliminary and post-repository medication, as suggested by Brown.[1,2] No constitutional reactions were noted. In only one instance did a patient, a boy of eleven years, experience soreness and swelling of the arm forty-eight hours after the repository injection. This responded readily to acetylsalicylic acid grains X and cold packs.

Doctor Appel and I are satisfied that this procedure is safe in this small number of children. We shall be happy to report the results of this pilot study at the conclusion of the oncoming ragweed season.

**Addenda**

October, 1959.—With our limited number of patients, the clinical results were at least as good as in other seasons. We plan to continue the study of repository treatment with pollen and other inhalant substances in a larger series of cases within the next twelve months.


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# The Physician's Role in Physical Fitness

The physician, as an individual, has the responsibility to practice good medicine, both therapeutic and preventive, in regard to the children whom he sees. In his community he has the obligation, both as an individual and as a representative of medicine, to cooperate with other professional persons and with other organizations so that the fitness activities of the community may be broadly conceived and be medically as well as educationally sound.

He has the additional responsibility of encouraging and supporting other activities related to this field of school health and fitness in his own state and nationally, so that there may be a medically sound approach to this very confusing problem. With each succeeding generation it raises its head, dressed in more confusion than when it last appeared.—Donald A. Dukelow, M. D., in Northwest Medicine.

# 93RD ANNUAL MEETING

of the

# *West Virginia State Medical Association*

## *The Greenbrier*

AUGUST 25-27, 1960

# The President's Page

*Guest Author, Myer Bogarad, M. D., Weirton, President, W. Va. Chapter, American Academy of General Practice*

## The General Practitioner

FOLLOWING World War II, the status of the General Practitioner was at its lowest ebb. We were a large disorganized group of medical men without leadership; however, in 1949 the American Academy of General Practice began to function. In just one decade since its organization, the Academy has become the country's largest medical organization with the exception of the American Medical Association.

I will always remember our first annual meeting in Cincinnati. It was an inspiration to all those who attended. Dr. Philip Thorek was the last speaker on the program and the auditorium was still filled to capacity. Men were actually standing because there were no chairs available.

The American Academy of General Practice was formed with several objectives in mind:

1. To provide postgraduate education for the General Practitioner. One must qualify every three years in order to be a member of the Academy. He must have fifty hours of Category I, and one hundred hours of Category II. Category I must be Academy approved lectures or medical school courses. Each year our West Virginia Chapter disqualifies some men because of their failure to keep up with postgraduate training.

2. To protect the right of the General Practitioner to engage in those surgical and medical procedures for which he is qualified by training and experience. We are the first ones to condemn any General Practitioner who asks for privileges for which he does not qualify.

3. To maintain the high standards of the General Practitioner so that he can better serve the general public.

4. To preserve the right of free choice of physician to all people.

Our West Virginia Chapter is not a political organization, and at no time have we as a group attempted to influence the election of officers of the West Virginia State Medical Association. We are dedicated to bringing postgraduate education to the members of our profession.

This year we have meetings planned for Charleston, Wheeling, Martinsburg, Morgantown and Bluefield, and non-members are cordially invited to attend. May I extend to all of you an invitation to attend our Eighth Annual Scientific Assembly in Charleston, May 6-8. The program on the first day will be sponsored by the West Virginia Cancer Society.

Some of our state medical societies are now awarding scholarships to medical students who will do General Practice in rural areas. Our own State Medical Association has initiated this plan. Our neighboring state of Virginia has placed about two hundred and fifty physicians in rural areas. This will assure good medicine to those areas that have been without the services of well qualified General Practitioners.

In the words of our immediate past president, the goal of the Academy is to elevate the standards of medical care by continuous medical education of the General Physician.

I wish to thank Dr. J. C. Huffman, President of the West Virginia State Medical Association, for the privilege of being his guest writer of the President's Page in the April issue of *The West Virginia Medical Journal.*

# THE WEST VIRGINIA MEDICAL JOURNAL

*Official Organ of the West Virginia State Medical Association*

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.



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*Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.*

*Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.*


# EDITORIALS

## PHYSICIANS AS CITIZENS

One of the most frequently repeated questions about the medical profession is this: "Are doctors community-minded?" Behind the query lies the continuing search to determine the balance between "service" and "self" among practicing physicians.

Speaking on behalf of its almost 1,500 members, the West Virginia State Medical Association can answer the question with a firm "Yes." Doctors within the 55 counties of this state compile a "lifetime of service within a year's time." This is not an idle boast, but an indisputable fact, supported by evidence gathered by Tom Cummings, Staff Writer for *The Charleston Daily Mail*, from reports of the widespread activities in which members of the profession engage.

Stories appearing in state newspapers, obtained through a clipping service operated by West Virginia Press Services, Inc., offer documented evidence of the many services performed by physicians beyond the hours of their daily practice. This record indicates that physicians maintain an annual record of some 250,000 hours of service—the startling total of 125 years if it could be computed on a working day basis.

Besides their speaking appearances before component societies or medical sections, physicians deliver from 87 to 104 speeches to members of other local or area groups within a month's time. Other hours they spend in meetings, conferences, as presiding officers, and in a counseling or advisory capacity.

As presidents of local Chambers of Commerce, physicians participate in community development authorities, and as members of zoning and planning commissions; they engage in voluntary health work, and are members of Civil Service Commissions; they hold important posts in the Boy Scout movement and other youth organizations, serve on cemetery and park boards, state commissions and agencies, as land conservation commissioners or as participants within municipal associations.

Conferences on varying community problems hold the attention of many doctors; they have active roles in Parent-Teachers Associations, manage youth athletic teams and aid in the direction of such programs.

The West Virginia Tree Farm Committee within the year past recognized at least three physicians for their management of Christmas tree farms or other forest areas for their efforts in natural resources, conservation and reproduction. Within this group, one serves as president of a growers' association and participates in the work of its national board. Another physician now nears the end of his fifth term as vice president of the national Isaak Walton League.

There are doctors engaged as horticultural specialists—in the production of roses, dahlias,

orchids and other flowers—in which fields they have attained high proficiency. Their knowledge is being shared by other persons who hear them speak and advise or show the products of their art.

In the field of commerce, a doctor now living in the northern part of the state has recently been elected to his 47th annual term as a bank president. Elsewhere in West Virginia, fellow physicians serve as bank directors and on boards of building and loan associations.

Turning toward education, the most recent issue of the *West Virginia Blue Book* confirms that physicians are members of school boards in 16 of the state's 55 counties. In this election year, the number may be increased. In another six counties, they have important community roles as county commissioners. Incorporation of the state's newest town found a doctor presiding at its birth and becoming its first mayor. This rank is held elsewhere by doctors as well as that of city councilman.

Doctors are found often as members of county Public Assistance councils, as commissioners of human relations and other civic bodies. The West Virginia University Board of Governors has a doctor as its chairman. Education groups find doctors adding considerably to their hours of community efforts.

A newspaper contest recently turned up a doctor as one of its prize-winning cooks, and a national small animal federation has a West Virginia physician as its president. Earlier this year a medical school official published a book of essays backgrounding the medical efforts of Doctor Watson of Sherlock Holmes fame.

But sometimes even the best intentions of doctors are thwarted. An instance was shown by a newspaper account of a beaver family seen in one of our counties after an absence of more than 20 years. There was much speculation about this phenomenon until a surgeon cleared away the mystery. The beavers he had installed on his own game preserve. Apparently becoming dissatisfied with their surroundings, the rodents moved elsewhere in the same district to build their dams and make a new home for their families.

On the other hand, doctors frequently receive citations for their volunteer organizational work, defense activity and their many community enterprises.

The volunteer spirit of doctors in West Virginia shows strongly in many helpful endeavors to their fellow men, other than their prime objective, the life-serving practice of medicine.

**LEGISLATIVE SEASON ENDS**

Now that the annual legislative season is ended, the Association may reflect on legislation of particular interest to the members of our profession. Senate Bill 31, pertaining to foreign graduates, was opposed by our Association by reason of unanimous recommendation of the Legislative Committee. This bill would have permitted the unlimited invasion of foreign doctors into West Virginia hospitals, without regard to credentials, until July 1961. At that date such foreign graduates would have to have passed the examination of the E.C.F.M.G. Such foreign physicians would not be under the supervision or control of the Medical Licensing Board.

The medical profession is often castigated for any interest in legislation. It has been stated by some of our critics, that political interest is an undesirable trait in physicians or medical associations. In a recent communication in our Journal, Volume 55, page 423, it is written "actually those doctors who are too busy for politics and have no taste for it, constitute our greatest strength against the progressive regimentation of the medical profession." By this token, we would now have been subjected to compulsory insurance, plus all the shackles devised by Senators Murray and Dingell and Secretary Ewing. A politically sound and alert attitude towards all medical legislation is our best hope to retain the remnants of "free choice" and "fee for service."

By reason of alteration of legal opinion, which formerly permitted no discrimination or individual consideration of hospitals or foreign graduates, the Medical Licensing Board has been able to assure all those hospitals with an approved teaching program that their interns and residents may complete their service. By invoking the emergency clause of the Medical Practice Act, the Medical Licensing Board now permits physicians in State institutions to practice therein so long as their services are acceptable to the institution and the Medical Licensing Board. Such physicians must apply for examination for regular licensure as soon as they become eligible by reason of medical credentials, residency and citizenship.

Foreign graduates are now permitted to remain in accredited non-teaching hospitals for 4 years (One year internship and three years' residency). There are now 33 foreign graduates in this category—22 in private hospitals and 11 in non-profit institutions. There is little, if any, teaching in these institutions. These foreign graduates are under permanent visas and can move about the United States as they choose. Some of them

came here under the Exchange Visitor Program, returned to the old country and shuttled back to the United States as soon as they could get a permanent visa. The Medical Licensing Board has neither funds nor personnel to supervise the activities of these doctors and is unable to determine if their services are capable, or if they are being exploited by hospitals. It is only within this small group that there are administrative difficulties.

This Medical Licensing Board policy in comparison with most states presents a very favorable situation for the foreign graduate. If further discriminatory powers could be given to the Board, it is probable that other acceptable usage, such as rural practice for foreign graduates, could be considered.

In this day when all medical care is subjected to the closest public scrutiny, it is commendable that our legislature chose to defeat Senate Bill 31.

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**OUR FRIENDS: THE FUNERAL DIRECTORS**

Probably the medical man does not always appreciate sufficiently his para-medical co-workers, and this is probably more true of the mortician than of any other of these. Embalming was a well developed science, or possibly we should say art, when medicine was only in its "swaddling clothes."

A recent editorial in *The Journal of the Medical Society of New Jersey* depicts well the relationship which should obtain between the two professions. Although unsigned, the style bespeaks the author as Dr. Henry A. Davidson, the versatile editor of that journal. His portrayal of the funeral director and the ideal rapport between the two callings is so well put that we quote the entire editorial:

"Physician do not like the odor of the tombstone around their work and many doctors shy away from the persistent social and professional contacts wtih funeral directors. This, however, is unrealistic reasoning. Funeral directors, as individuals, are no doubt jolly fellows who make very good social companions. More important than that, however, the funeral director can be a friend in need to the physician not only at the time of a death among his patients but also as an ally in some of the doctor's legal, administrative and legislative battles.

"To begin with, the work of the mortician is properly considered a professional activity. The funeral director needs skills in the embalming of bodies as well as in the complex operation of a modern funeral and the legal details surrounding a death and a burial. The funeral director has to be recognized as a professionally trained individual.

"The handling of a funeral requires considerable tact and delicacy. Funeral directors are, by and large, trained to exercise these qualities. It is common for the bereaved families to blame the doctor and they often cry on the shoulders of funeral directors. No one knows how often the mortician has assuaged the guilt feelings and his neutralized open or latent feelings of hostility against the physician.

"The mortician is a great help in the preparation and validation of a death certificate. Many doctors can recall examples of how undertakers had to track them down and get the signature on the death certificate to prevent legal complications.

"The funeral director who is well disposed toward the medical profession in general and the attending physician in particular will often delay the embalming of a body or detour bodies over long distances to facilitate an autopsy. Actually, funeral directors to a far greater extent than most physicians realize, help get permission for post-mortem examinations. One physician has estimated that in his community the autopsy rate has gone up at least ten per cent because of the assistance of funeral directors.

"In the antiquity of their calling, the morticians need not take a back seat to anybody. Embalmers had achieved professional status in Europe and Asia at a time when many branches of medicine were still at the stage of a skilled craft. Morticians have been the victims of an understandable prejudice against them because no one likes to be reminded of death. For this reason, they had been denied the professional recognition which has been awarded to dieticians, nurses, pharmacists and psychologists. Yet, when the chips are down, it must be conceded that the professional mortician is indeed a practitioner of a very ancient and skilled science.

"Mark Twain used to say that the sign of a good life was when even the undertaker was sorry that the man died. As usual, Mark Twain was a wise man."

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**GERONTOLOGY IN RHYME**

For the past two decades the increase in the segment of our population beyond the so-called retirement age of sixty-five has stimulated gerontological research and much discussion of the problems of aging and now the rhymester has invaded the geriatric field. We clipped the following from a recent issue of *The New England Journal of Medicine*. While possibly it does not outclass the poetry of the

immortal New Englander Longfellow, it does demonstrate that sixty-five is not always the proper age for retirement.

The author, an architect, nearing fourscore, clearly demonstrates the truth of Walter Bierring's dictum, "the rocking chair is not the answer to the aging problem."

The final stanza, the "Note," we assume is the handiwork of the versatile editor of the New England Journal, Dr. Joseph Garland. We quote the complete poem:

De Senectute—A Geriatric Jingle

William Roger Greeley
Boston

Deft of finger, full of fire,
Old Socrates at seventy-one
Set out to learn the Lute and Lyre
And found it hard but lots of fun.

Armed with pep and self-reliance
Tom Edison at seventy-six
Began to build a weird appliance
To telegraph across the Styx.

Great Grandma Moses, young at heart,
Got tired of chores at seventy-eight,
She found some paint and turned to art,
And now her pictures hang in state.

Round of paunch and keen of wit
At eighty Franklin chaffed the boys
And guided them (and William Pitt)
With perspicacity and poise.

Spry of foot, of eye tenacious,
King Gustaf played a game so mighty
He snatched top laurels from teen-agers
Nor layed his racket down till ninety.

Fresh, untiring, clear of mind,
Did Theophrastus, ninety young,
Begin his great book on mankind,
For which his praises still are sung.

Feeble in frame and frail of leg
Old Titian painted all the harder.
It took the Asiatic plague
At ninety-nine to quench his ardor.

Putting younger men to shame
Old Monaldeso took his pen
At one fifteen and rode to fame
By writing memoirs there and then.

You are old and I am old:
These older men were younger.
A hunger made them young and bold:
Let's cultivate a hunger.

For the fault, dear Brutus, lies
Not in weight of years, NO, Brutus!
But in our subtle alibis
Because our stars don't suit us.

Find a pot of paint, dear boy,
A racket or a chisel:
Your dotage, seasoned then with joy,
Can scarce be termed a fizzle.

*Note:*

And don't forget revengeful Cato,
Whom Carthage wished beneath the sod;
He was another late tomato
Who mastered Greek at eighty odd.—Ed.

## SIGNIFICANCE OF FEDERAL EMPLOYEES HEALTH ACT

The Federal government, as an employer, the largest employer in the U.S.A., is about to provide medical care security to some 4 million Federal employees and their dependents.

Under the new Health Benefits Act passed by Congress last September, government workers will begin to enroll about June 1, 1960 in one or another of four types of hospital and medical care programs: (1) a service benefit plan (Blue Cross-Blue Shield); (2) an indemnity plan (underwritten by an insurance company); (3) an employee organization plan (of which a considerable number have been set up by Federal employee organizations); and (4) a comprehensive "closed panel" plan (such as the Kaiser Health Plan or H.I.P.), where such programs exist.

Federal contributions will commence in July toward the cost of whatever plan may be selected by each Federal worker.

Each employee will have the utmost freedom to choose among the specific plans to be approved by the U. S. Civil Service Commission in negotiations now going on between the Commission and the "carriers" of the four types of program specified in the Act.

Our government has shaped its program in accordance with the mutual desire of its employees and their doctors for a free choice of physician and plan.

To meet the natural requirements of the Civil Service Commission for a reasonable degree of uniformity among the programs offered by the 79 Blue Cross and the 67 Blue Shield Plans, many Plans will have to alter or add to their established benefit provisions. This will call for cooperation among those who are providing services to patients under local Blue Shield Plans.

The significance of the Federal Employee Health Benefits Act for the future of American medicine can scarcely be exaggerated. Under the terms of this act, our government will contribute toward the cost of a hospital and medical care coverage program for all Federal employees. Thus, the government as an employer assumes a direct interest in, and responsibility for the health care of its career servants.

Moreover, the government may be expected to scrutinize the effectiveness of the coverage provided in order to assess the capacity of our voluntary programs to function in an acceptable fashion in meeting the public's need for "prepaid" health services.

# GENERAL NEWS

## Dr. Charles B. Jolliffe Honor Guest At Annual Meeting in August

Dr. Charles B. Jolliffe, a native West Virginian and one of the world's leading authorities in the field of electronics, has accepted an invitation to appear as a guest speaker at the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

Doctor Jolliffe is Vice President and Technical Director of the Radio Corporation of America, having been named to that post in September, 1951. He is also Technical Director of RCA Defense Electronic Products and is a member of the Board of Directors of RCA, the National Broadcasting Company, and RCA Communications, Inc. He became associated with RCA in 1935.

### First Speaker on Program

Dr. Seigle W. Parks of Fairmont, the chairman of the Program Committee, announced that Doctor Jolliffe will be the first speaker on the program arranged for Thursday morning, August 25.

His address will follow opening remarks by Doctor Parks and Dr. J. C. Huffman of Buckhannon, president of the West Virginia State Medical Association. His subject will be announced at a later date, but it is now thought it will be on the general subject of electronics.

### Native of Mannington, West Virginia

Doctor Jolliffe was born in Mannington, West Virginia, on November 13, 1894, son of Charles E. and Sallie Vandervort Jolliffe. He was graduated from West Virginia University in 1915 and received a Master's degree from the same school in 1920. He received a Ph.D. degree from Cornell University in 1922.

In 1942, he was awarded an honorary LL.D. degree by West Virginia University.

From 1916 to 1922, except for a period of service in World War I, he taught physics at Ohio State University, West Virginia University and Cornell University. He accepted a position with the Radio Section of the Bureau of Standards in 1922 and served there for eight years.

### Joined RCA in 1935

In 1930, Doctor Jolliffe was appointed Chief Engineer of the Federal Radio Commission and held that position with the FRC, and its successor, the Federal Communications Commission, for five years. Upon his resignation in November, 1935, he became associated with RCA and has held the successive positions of Engineer in Charge, RCA Frequency Bureau; Chief Engineer, RCA Laboratories; Assistant to the President of RCA; Vice President and Chief Engineer of the former RCA Victor Division; and Executive Vice President in charge of RCA Laboratories Division.

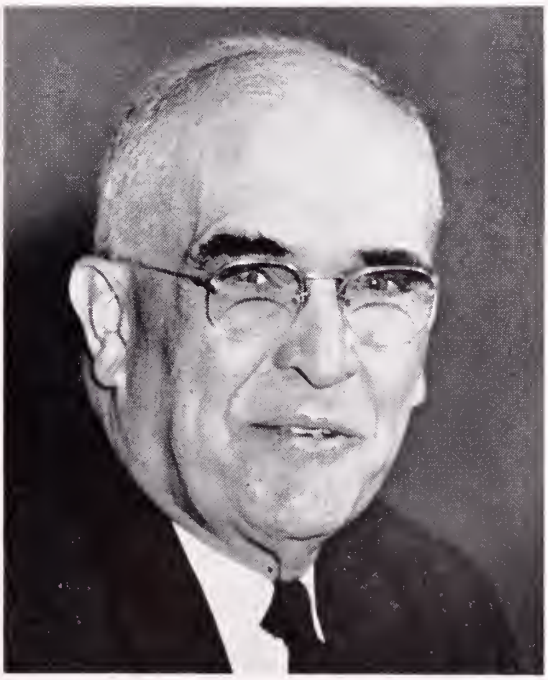
During World War II, he served as Chairman of the Communications Division of the National Defense Research Committee, Office of Scientific Research and Development. He also was Secretary of the Industry Advisory Committee, Board of War Communications, and a member of the Engineers Defense Board. For his wartime contributions to the OSRD, he received Army and Navy Certificates of Appreciation.

### Scientific Program Nearly Completed

Doctor Parks and the other members of the Program Committee have almost completed arrangements for the general scientific program which will be presented during the three-day meeting. The names of the prominent physicians and surgeons who will appear as guest speakers will be announced in future issues of *The Journal.*

### Program by WVU School of Medicine

It has been announced previously that the program for the second general session on Friday morning, August 26, will be presented by members of the faculty



Dr. Charles B. Jolliffe

of West Virginia University School of Medicine. Other University officials will also appear on the program.

### AMA President to Speak

Dr. E. Vincent Askey of Los Angeles, California, who will be installed as president of the American Medical Association at the annual meeting of that organization in June, will attend the meeting and speak before the second session of the House of Delegates on Saturday afternoon, August 27.

Dr. J. C. Huffman, president of the State Medical Association, will deliver his presidential address before the first session of the House of Delegates on Wednesday evening, August 24.

## Heavy Room Reservations At The Greenbrier

Reservations for the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27, are approaching the 300 mark as this issue of *The Journal* goes to press.

The management has again assured Association officials that every effort will be made to arrange accommodations for all those who are interested in attending the convention. It is important, however, that reservations be made as soon as possible so that some idea may be had by the management concerning the total number of rooms that will be needed to house those attending the meeting in August.

Requests for rooms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, W. Va.

## Plans Completed for Oph. and Otol. Meeting at The Greenbrier

Members of the State Medical Association have been extended a cordial invitation to attend the 13th Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology which will be held at The Greenbrier in White Sulphur Springs, April 10-12.

Dr. Albert C. Esposito of Huntington, the program chairman, announced that five prominent physicians have accepted invitations to appear as guest speakers before the general scientific sessions which will be held on Monday and Tuesday mornings, April 11-12. Each speaker will present two scientific papers during the meeting.

Dr. N. K. Joseph of Wheeling, the president, will preside during the three-day meeting.

### Bacteriologists To Meet in Philadelphia

The 60th general meeting of the Society of American Bacteriologists will be held in Philadelphia, May 1-5, 1960. More than 450 papers representing studies in bacteriology and microbiology will be presented during the five-day meeting.

## Public Health Association Meeting In Bluefield, May 11-13

The 36th annual meeting of the West Virginia Public Health Association will be held at the West Virginian Hotel in Bluefield, May 11-13. The theme of the conference will be "Meeting New Responsibilities in Public Health."

Eugene J. Powell of Charleston, president of the Association, will preside during the three-day meeting which is expected to attract more than 250 professional and voluntary workers interested in the advancement of public health in West Virginia.

Registration will open at 5 P. M. on Wednesday, May 11, and a dinner meeting of the Executive Council will be held at 6:30 o'clock

The first general session will be held on Thursday morning, with Mr. Powell presiding. Addresses of welcome will be delivered by the Honorable T. Courtney Tanner, Mayor of Bluefield, and Dr. Daniel Hale of Princeton, chairman of the Mercer County Board of Health.

The first speaker will be Dr. Eugene A. Gillis of Charlottesville, Virginia, Regional Director, United States Public Health Service. Other speakers on the morning program will be Dr. Eugene H. Guthrie of Washington, D. C., Chief, Program Services, Bureau of State Services, USPHS, whose subject will follow the theme of the meeing, and Dr. N. H. Dyer, State Director of Health, who will discuss "New Responsibilities in Public Health in West Virginia."

The second general session will be held at 8 o'clock on Thursday evening. The speaker will be Dr. Edward G. McGavran, Dean, University of North Carolina School of Public Health.

Dr. E. E. Myers of Philippi, first vice president of the Association, will preside at the third general session on Friday morning, May 13. The program will consist of a panel discussion following the theme of the meeting.

Dr. Eugene H. Guthrie of the USPHS will serve as moderator and the members of the panel will be as follows:

Dr. E. G. McGavran, Chapel Hill, North Carolina; Zella Bryant, Acting Chief, Division of Public Health Nursing, USPHS; William C. Gibson, Acting Dean, University of Michigan School of Public Health; Josephine W. Gutridge, Regional Records Consultant, USPHS; and Mabel Rugen, Professor of Health Education, University of Michigan.

The afternoon programs on Thursday and Friday will be devoted to meetings arranged by the various sections of the Association.

A reception honoring the president of the Association will be held on Friday evening and will be followed by a banquet in the ballroom of the West Virginian Hotel. Mr. Powell will deliver his presidential address at the banquet, and awards also will be presented at that time. A dance will follow the banquet.

Dr. N. Allen Dyer of Bluefield, Mercer County Health Officer, is chairman of the committee making arrangements for the meeting.

## West Virginia Chapter, AAGP, To Meet In Charleston, May 6-8

More than 300 physicians are expected to attend the Eighth Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice, which will be held at the Daniel Boone Hotel in Charleston, May 6-8.

Dr. J. Keith Pickens of Clarksburg, general chairman of the convention, announced that 13 prominent physicians and surgeons have accepted invitations to appear as guest speakers on the scientific program. General scientific sessions will be held in both morning and afternoon on Saturday and Sunday, in addition to an afternoon session on Friday.

Myer Bogarad, M. D.

George Crile, Jr., M. D.

### Cancer Society Program

Dr. Richard E. Flood of Weirton, the program chairman, has announced that registration for the three-day meeting will open at 1 P. M. on Friday, May 6. The scientific session that afternoon will be co-sponsored by the West Virginia Division of the American Cancer Society and the papers will be devoted to subjects related to cancer.

There will be three speakers: Dr. C. Bernard Brack of the Johns Hopkins Hospital, Baltimore, Maryland, will discuss "Uterine Carcinoma and Cytology," and Dr. Emerson Day of the Sloan Kettering Institute, New York City, will present a paper on "Cancer Detection." Dr. John J. Conley of New York City will also speak that afternoon on a subject to be announced.

### Dr. Myer Bogarad To Preside

Dr. Myer Bogarad of Weirton, the president, will call the meeting to order officially at 9 A. M. on Saturday, May 7. Brief addresses of welcome will be delivered by Dr. J. C. Huffman of Buckhannon, president of the West Virginia State Medical Association; Dr. Milton J. Lilly, Jr., president of the Kanawha Medical Society; and Mr. Charles Lively, executive secretary of the State Medical Association.

### Dr. Pickens To Be Installed as President

Dr. J. Keith Pickens of Clarksburg, the president elect, will be installed as president during the meeting, succeeding Doctor Bogarad. Other officers are Dr. Don S. Benson of Moundsville, vice president; Dr. Randall Connolly of Parkersburg, secretary; and Dr. Joseph A. Smith of Dunbar, treasurer. Dr. Seigle W. Parks of Fairmont, immediate past president, is chairman of the Board of Directors and editor of *Mister Doc*, official publication of the Chapter.

### Pre-Convention Meetings

The Chapter's Board of Directors will meet on Thursday afternoon, May 5, and several committee meetings have been scheduled for that evening. The House of Delegates will be convened at 10 o'clock on Friday morning, May 6, and the official order of business will include an address by Dr. Myer Bogarad of Weirton, the president, and reports of officers and chairmen of various committees.

### Scientific Program

The following physicians, whose subjects will be announced at a later date, will appear as guest speakers on the morning and afternoon scientific programs on Saturday and Sunday:

*Saturday Program:* 9:15—Cornelius E. Sedgwick, M. D., Lahey Clinic, Boston; 10:00—Elmer E. Bartels, M. D., Lahey Clinic, Boston; 11:30—Paul DeCamp, M. D., Ochsner Clinic, New Orleans; 2:00—Robert L. Forsyth, M. D., Pittsburgh; 3:30—G. Alexander Koelsche, M. D., Mayo Clinic, Rochester, Minnesota.

*Sunday Program:* 9 A.M.—George Crile, Jr., M. D., Cleveland Clinic; 9:45—E. A. Gaensler, M. D., Boston City Hospital, Boston; 11:15—Victor deWolfe, M. D., Cleveland Clinic; 2:00—William D. Parsons, M. D., Jackson Clinic, Madison, Wisconsin; 2:45—George T. Pack, M. D., New York City.

George T. Pack, M. D.

Victor deWolfe, M. D.

Doctor Flood said that adequate time has been allotted for question and answer periods following both morning and afternoon sessions. Breaks will be provided during the sessions to enable physicians to visit the scientific and technical exhibits.

### Dr. Perry E. Gresham Banquet Speaker

Dr. Perry E. Gresham, president of Bethany College, will be the speaker at the banquet on Saturday evening, May 7. A social hour will precede the banquet and

a cabaret dance for physicians, their wives and guests will be held in the ballroom following the banquet.

Dr. Tracy N. Spencer, Jr., of South Charleston, is chairman of the committee in charge of local arrangements.

**Entertainment for Wives of Physicians**

An entertainment program is being arranged for wives of physicians attending the meeting. The registration desk will open on Friday afternoon and an interesting program is planned for the remainder of the three-day meeting.

## American Heart Association Meeting In St. Louis, Oct. 21-25

The Annual Meeting of the American Heart Association will be held at Kiel Auditorium in St. Louis, October 21-25. The 33rd Scientific Sessions will be held October 21-23.

The deadline for submitting abstracts of papers to be presented at the meeting is June 1. Papers intended for presentation must be based on original investigations in, or related to the cardiovascular field. The same deadline applies for applications for space in the scientific exhibit hall.

Further information concerning the meeting may be obtained by writing to Dr. F. J. Lewy, Assistant Medical Director, American Heart Association, 44 E. 23rd Street, New York 10, New York.

## Booklet on Rheumatic Fever Available

A revised statement on "Prevention of Rheumatic Fever and Bacterial Endocarditis through Control of Streptococcal Infections" has been published by the American Heart Association. Physicians may obtain copies of the leaflet by writing to the West Virginia Heart Association, 1906 E. Washington Street, Charleston, West Virginia.

## Dr. A. C. Esposito to Present Paper At ICS Meeting in Rome

Dr. Albert C. Esposito of Huntington will participate in a symposium in connection with the 12th Biennial International Congress of the International College of Surgeons' in Rome, Italy, May 14-19, 1960. He will present a paper on the subject of "Cataract and Allied Ocular Surgery."

He will discuss his technique in cataract surgery and the use of his Erisophake which was mentioned in an article published in the British Journal of Ophthalmology and other European journals in 1952. He will also discuss techniques in congenital cataract, glaucoma and enucleation surgery.

The Rome convention of the International College of Surgeons will be held under the auspices of the President of Italy at the Palazzo dei Congressi - Esposizione Universale di Rome (E.U.R.).

While in Europe, Doctor Esposito will be honored by being inducted into the Societe Francaise D'Ophthalmologie in Paris, France.

## Seminar on 'Pre-School' Health Planned At WVU Medical Center in June

A seminar on "Growth and Development of the Pre-School Child" will be held at the West Virginia University Medical Center in Morgantown, June 29-30. The two-day meeting will be sponsored by the State Department of Health and the State Department of Public Assistance, in cooperation with several professional and voluntary groups in the state.

Dr. Clark K. Sleeth of Morgantown, assistant to the dean, WVU School of Medicine, will call the meeting to order on Wednesday morning, June 29, and will preside during the morning and afternoon sessions. Addresses of welcome will be delivered by Dr. N. H. Dyer, State Director of Health, and Thomas R. Egbert, State Director of the Department of Public Assistance.

**Program for Wednesday, June 29**

The following program has been arranged for Wednesday, June 29:

"Cultural and Sociological Influences on Development."—Ethel J. Alpenfels, Ph.D., Professor of Anthropology, New York University, New York City.

"Intrauterine Development and Environment."—James Donnley, M. D., Director, Division of Maternal and Child Health, North Carolina State Health Department.

"Stages of Personality Development."—Florence Blake, Director of Nursing Research, University of Chicago.

"Communicative Skills."—Miriam D. Pauls, Ph.D., Hearing and Speech Center, Johns Hopkins Hospital, Baltimore.

"Developmental Aspects of Vision, Reading Skills and Deviations."—Edwin M. Shepherd, M. D., Shepherd Hospital, Charleston.

**Thursday's Program**

Dr. M. A. Viggiano, health officer of the Monongalia County Health Department, will preside at the session on Thursday, June 30. The following program will be presented:

"Communicative Skills—With Special Attention to Skeletal and Neuromuscular Aspects of Development and Recognition of Deviation."—Justus C. Pickett, M. D., Morgantown.

"Influence of Handicapping Conditions on the Child."—Paul Lemkau, M. D., Professor of Mental Hygiene, Johns Hopkins University School of Medicine, Baltimore.

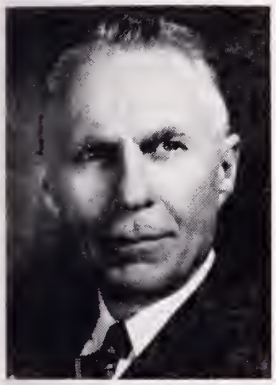
"Educational Problems of the Pre-School Child."—Louise Bates Ames, Ph.D., Director of Research, Gesell Institute of Child Development, Yale University, New Haven, Connecticut.

"The Pre-School Child and the Community."—Madeleine E. Morey, M. D., Regional Medical Director, Children's Bureau, USPHS, Charlottesville, Virginia.

Physicians are cordially invited to attend the seminar. Further information may be obtained by writing the Division of Maternal and Child Health, State Department of Health, The Capitol, Charleston 5, West Virginia.

## Special Program at WVU To Honor Retiring Dean E. J. Van Liere

Plans have just about been completed for a special program which will be presented at a meeting at the Medical Center in Morgantown on Thursday afternoon, May 12, honoring Dr. E. J. Van Liere who will soon retire as Dean of the West Virginia University School of Medicine, a post he has held since 1935.



E. J. Van Liere, M. D.

The meeting will get under way at two o'clock with the introduction of out-of-town guests, including many of the Dean's friends and colleagues of the several professional groups active in the health arts and sciences throughout West Virginia.

### Out-of-State Speakers on Program

The principal speakers on the program will be Dr. Carl J. Wiggers of Cleveland, Ohio, and Dr. David Bruce Dill of the Army Medical Center in Maryland. Each of the speakers have over the years made outstanding contributions to physiology and allied fields of medical science.

Doctor Wiggers, distinguished physiologist and longtime friend of Dean Van Liere, is Emeritus Professor of Physiology at Western Reserve University in Cleveland, where he served for many years as head of the Department of Physiology. He is widely known in his profession as an authority on the functions of the heart and circulation. Medical students and instructors will remember him as the author of the textbook, "Physiology in Health and Disease."

Doctor Dill, a noted authority in the field of hypoxia, is Deputy Director of Medical Research at the Chemical Warfare Laboratories of the Army Medical Center in Maryland. For many years, he was associated with the Fatigue Laboratory of Harvard University. It is said that physiological science is indebted to him for his many contributions, especially toward our understanding of man exercising, man in the desert, and man at altitude.

### Portrait To Be Unveiled

Following the scientific program, Dean Van Liere's portrait will be unveiled and formal presentation made to the University. Following its acceptance by the president, Dr. Elvis J. Stahr, Jr., there will be a reception honoring the Dean.

The portrait is now being painted by Mrs. Homer Clark of Boston, with sittings at the West Virginia Medical Center.

Following his retirement, Dean Van Liere will continue to serve on the faculty as Professor of Physiology.

## Membership Drive Launched By Southern Medical

The Southern Medical Association announced recently that it has launched an active campaign to enlist as members of the organization more than 1,000 physicians practicing in West Virginia.

Dr. Howard A. Swart of Charleston, a member of the Council, said that approximately 330 state physicians are now members and it is hoped that a large number of the other qualified physicians will accept the invitation to join.

A letter over the signatures of Doctor Swart and the associate councillors in West Virginia was mailed recently to non-members outlining the benefits of membership in the Association. The associate councillors are Drs. Thomas H. Blake, St. Albans, Harold H. Howell, Madison, W. F. Shirkey, Charleston, and Walter E. Vest and Albert C. Esposito, Huntington.

Doctor Swart said benefits of membership in the Association include a subscription to the *Southern Medical Journal*, an insurance program providing maximum protection and benefits to physicians and their families, and the annual meeting which attracts some 6,000 persons from the United States and abroad.

Three West Virginia physicians, all Huntington residents, have served as president of the Association, Dr. Thomas W. Moore in 1929, Dr. Walter E. Vest, 1939, and the late Dr. Robert J. Wilkinson, 1952.

At the Association's 1959 annual meeting in Atlanta, Doctor Moore was cited for having attended more annual meetings than any other member. He also received the Association's Distinguished Service Award in 1958.

The 54th annual meeting will be held in St. Louis, October 31-November 3, 1960.

## Fellowships in Ophthalmology Offered By Guild of Prescription Opticians

Six additional Fellowships for Residents in Ophthalmology will be awarded July 1, 1960, by the Guild of Prescription Opticians of America, Inc. Announcement of these new awards were made earlier in the month by the Guild's president, William T. Heimlich of Ithaca, New York.

Application forms for the Fellowships, each of which is for a total of $1800, payable in monthly stipends over the period of a three-year residency, may be obtained by writing to Fellowships, Guild of Prescription Opticians of America, Inc., 110 East 23rd Street, New York 10, N. Y.

## Cardiovascular Seminar in Miami Beach

The Sixth Biennial Cardiovascular Seminar, sponsored by the Florida Heart Association, the Florida State Board of Health and the Heart Association of Greater Miami will be held at the Balmoral Hotel in Miami Beach, April 27-30, 1960.

Full information concerning the program may be obtained by writing the Heart Association of Greater Miami, Inc., 2 S. E. 13th Street, Miami 32, Florida.

## Carolinas-Virginias Hospital Conference at Roanoke

J. Harold Laughlin of Charleston will preside at the 30th Annual Meeting of the Carolinas-Virginias Hospital Conference which will be held at the Hotel Roanoke, in Roanoke, Virginia, April 21-22. The theme of the meeting is "Hospital of the Future—A Challenge to Administration."

J. Harold Laughlin

Mr. Laughlin, who is president of the West Virginia Hospital Association and administrator of Staats Hospital in Charleston, will deliver an address of welcome at the opening session on Thursday morning, April 21.

Steve J. Soltis, administrator of Beckley Memorial Hospital and chairman of the program committee for the meeting, has announced that 12 leading authorities on hospital problems have accepted invitations to appear as guest speakers.

Among the speakers will be Aubrey D. Gates of Chicago, director of the Field Service Division of the American Medical Association, and George Bugbee, president of the Health Information Foundation.

There will be two panel discussions during the meeting. Frank S. Groner, president elect of the American Hospital Association, will serve as moderator of the panel on "Problem of Financing Hospital Care for the Aged and Aging," and James M. Daniel, a member of the Board of Trustees of the AHA, will be the moderator of a panel discussion on "The Impact of Prepayment Plans on the Hospital of the Future."

The West Virginia Hospital Association is the host association for the four-state meeting which will mark the 30th anniversary of the Conference. The first meeting was held in 1930 at Durham, North Carolina.

## Dr. W. H. St. Clair of Bluefield Receives Award as 'Outstanding Citizen'

Dr. Wade H. St. Clair of Bluefield, a past president of the West Virginia State Medical Association, was honored recently by being named "Bluefield's Outstanding Citizen for 1960."

The award is given annually by the Riley-Vest American Legion Post in that city to an individual whose work has been outstanding in bettering the general conditions of the city.

Doctor St. Clair, who was one of the founders of the Bluefield Sanitarium, was cited for his "great contributions toward making Bluefield and this section of the country predominant as a medical center."

He was also praised for his business and civic interest and his general support of "all things good for the community."

### Relocations

Dr. Richard J. Lilly of Charleston, former Director of the Department of Mental Health, has located in Parkersburg for the practice of his specialty of psychiatry. He has offices at 325 Seventh Street in that city. He served as superintendent of Weston State Hospital for several months prior to his appointment by Governor Cecil H. Underwood as State Director of Mental Health. He assumed the duties of that office on May 12, 1959, and served as director until February, 1960.

* * * *

Dr. William R. Wolverton of Piedmont, who just recently completed a residency in orthopedic surgery at Children's Hospital in Little Rock, Arkansas, has located at Kingwood, where he is associated in practice with Dr. John W. Trenton at the Preston County Hospital.

* * * *

Dr. Samuel S. DuPuy, formerly of Scarbro, Raleigh County, who has completed a two-year residency in pediatrics at the Jackson Memorial Hospital in Miami, Florida, is now associated with Dr. William A. Pacetti, Jr., in the practice of his specialty. They have offices at 138 Almeria Avenue in Coral Gables, Florida.

* * * *

Dr. C. Glen McCoy, who practiced medicine at Elm Grove for many years, has retired and moved to Florida. His address there is 555 Burleigh Avenue, Holly Hill.

## Drs. Sexton and Ryan Present Papers At Williamsburg Meeting

Two West Virginia physicians presented papers at the recent annual meeting of the American Academy of Occupational Medicine, which was held at the Williamsburg Inn in Williamsburg, Virginia, February 11-13.

Dr. Richard J. Sexton, Medical Director of Union Carbide Chemicals Company, South Charleston, West Virginia, appeared on a program which followed the theme, "The Hazard to Health in the Hyrogenation of Coal." The subject of his paper was "An Introductory Statement on General Information, Process Description and a Definition of the Problems."

Dr. Eugene J. Ryan of Charleston, Medical Director of the E. I. du Pont de Nemours and Co., Inc., in Belle, presented a paper on "A New Challenge for Occupational Medicine."

## Maryland Medical Society to Meet In Baltimore, Apr. 20-22

The 162nd Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland will be held at the Alcazar, in Baltimore, April 20-22, 1960.

Full information concerning the scientific program may be obtained by writing Nathan E. Needle, M. D., Chairman of the Committee on Scientific Work and Arrangements, 1211 Cathedral Street, Baltimore.

## State Medical Assistants To Meet At Blackwater Falls, May 21

The program for the annual meeting of the West Virginia Association of Medical Assistants has been completed. Members and guests will be registered at Blackwater Falls Lodge near Davis at noon, Saturday, May 21, and the first business session will get under way at two o'clock, with the president, Mrs. Esther Raisbeck of Charleston, presiding.

The address of welcome will be delivered by Mr. Clay Whetsell of Elkins. The movie, "How To Become a Better Medical Assistant," will be shown at three-thirty o'clock and adjournment is scheduled for four-thirty.

A social hour will precede the annual banquet which will be served at seven o'clock, with Dr. Donald R. Roberts of Elkins as the guest speaker.

The session on Sunday, May 22, will be opened at 10:00 A. M. with the invocation by the convention chairman, Mrs. Virginia Goddin of Elkins.

A representative of the Aetna Casualty and Surety Company will present a paper on the subject of "The Doctor, the Medical Assistant, and Legalities."

The morning session will close with an address by Dr. J. C. Huffman of Buckhannon, President of the West Virginia State Medical Association. He will discuss "Medical Ethics."

Luncheon will be served at twelve o'clock, and the final business session will follow. New officers will be elected as the final order of business.

## New Heart Association Booklet On Coronary Atherosclerosis

A booklet, "Heart Disease Caused by Coronary Atherosclerosis," published by the American Heart Association and designed for distribution by physicians to their heart patients, has been revised and is now available to physicians.

Contents include a discussion of heart attacks and the process of recovery, explanation of the nature and treatment of angina pectoris, and a diseription of the atherosclerotic process.

Copies of the booklet may be obtained by writing to the West Virginia Heart Association, 1906 E. Washington Street, Charleston, West Virginia.

## Annual Medical Writers' Institute

The third annual Medical Writers' Institute, sponsored by Rensselaer Polytechnic Institute, will be held on the campus of that school in Troy, New York, June 12-17.

The five-day institute is designed for writers engaged in serving the medical, pharmaceutical and allied professions. The program consists of lectures, workshops, discussion groups and personal conferences with members of the faculty and visiting staff.

Further information may be obtained by writing to Jay R. Gould, Director, Medical Writers' Institute, Rensselaer Polytechnic Institute, Troy, New York.

## Medical Meetings, 1960

The following is a partial list of national, state and district medical meetings scheduled for 1960:

Apr. 1-2—W. Va. Chap., ACS, White Sulphur Springs.
Apr. 4-8—ACP. San Francisco.
Apr. 10-12—W. Va. Acad. Oph. & Otol., White Sulphur Springs.
Apr. 18—Medical Licensing Board, Charleston.
Apr. 21-22—Carolinas-Virginias Hospital Conference, Roanoke, Va.
Apr. 29-30—W. Va. State Society of Technologists, Charleston.
May 6-8—W. Va. Chap. AAGP, Charleston.
May 12-13—W. Va. PH Assn., Bluefield.
May 21-22—W. Va. Assn. Medical Assistants, Blackwater Falls Lodge.
June 13-17—AMA Annual Meeting, Miami Beach, Fla.
**Aug. 25-27—93rd Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.**
Sept. 13-15—National Cancer Conf., Minneapolis.
Sept. 14-16—Southern Trudeau Soc., Charleston, S. C.
Sept. 22-24—W. Va. Hospital Assn., White Sul. Springs.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 10-14—ACS, San Francisco.
Oct. 21-25—Am. Heart Assn., St. Louis.
Oct. 21-23—PG Institute, Martinsburg.
Oct. 31-Nov. 3—Southern Medical, St. Louis.
Nov. 29-Dec. 2—AMA Clinical Meeting, Washington, D. C.

### Change in Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston 24, West Virginia.

## Rocky Mountain Cancer Conference In Denver, July 20-21

The 14th annual Rocky Mountain Cancer Conference will be held at the new Denver Hilton Hotel in Denver, Colorado, July 20-21, 1960. About nine hundred physicians from over the country are expected to attend the two-day scientific session, for which 10 AAGP Catagory I credits will be allowed.

This regional annual cancer control meeting is sponsored by the Colorado Division of the American Cancer Society and the Colorado State Medical Society.

Tentative plans call for a symposium on "Skin Cancer" on Wednesday morning, July 20, and a symposium on "Thyroid Lumps" on the following morning. Afternoon sessions on both days will be devoted to the presentation by six outstanding physicians of papers on cancer detection and treatment.

Further information concerning the Conference may be obtained by writing Rocky Mountain Cancer Conference, 835 Republic Building, Denver, Colorado.

## Spring Meeting of MLB, April 18

The spring meeting of the Medical Licensing Board will be held at the New State Office Building in Charleston on April 18, 1960, for the purpose of examining applicants to practice medicine in West Virginia by reciprocity with other states.

## Duke School of Medicine Arranging Medical Seminar Cruise

Duke University School of Medicine has again arranged a cruise which will provide physicians with an opportunity to combine postgraduate study with an overseas vacation. This will be the Fifth Medical Seminar Cruise arranged by the University.

This year's cruise will take doctors to the Baltic, visiting LeHavre, Cuxhaven, Leningrad, Helsinki, Stockholm, Copenhagen, and Hamburg. The cruise ship, "T. S. Ariadne," will sail from Wilmington, North Carolina on June 5 and from New York City on June 8. The cruise will terminate in Hamburg, Germany, on June 28.

Shipboard lectures will be given on various subjects in medicine, pediatrics and thoracic surgery, and arrangements are also being made for lectures in the medical centers at Leningrad, Helsinki, Stockholm, and Copenhagen.

The medical program has been approved by the American Academy of General Practice for Category I Credit.

Full information concerning the cruise may be obtained by writing W. M. Nicholson, M.D., Box 3017, Duke University Medical Center, Durham, North Carolina.

### Proposed Constitutional Amendment

The following amendment to the Constitution of the West Virginia State Medical Association offered at the 92nd Annual Meeting at The Greenbrier in White Sulphur Springs, August 20-22, 1959, by James S. Klumpp, M. D., of Huntington, Chairman of the Committee on Constitution and By-Laws, will be acted upon finally by the House of Delegates at the 93rd Annual Meeting at The Greenbrier, August 25-27, 1960:

**Art. V**

Sec. 1. Amend the section by adding at the end thereof the following: "and (4) one delegate from each section and affiliated association and society which has been accepted and approved by the Council."

(The effect of the amendment would be to expand the membership in the House of Delegates so as to include a delegate from each Council-approved section and affiliated association and society).

## Sharp Increase in 'Pop' Tax Collections

Collections of the tax on soft drinks, reported by the State Tax Commissioner for the month of February, 1960, totaled $241,229.74, an increase of 27.4 per cent over the same month in 1959, when collections totaled $189,292.71.

Combined collections of the tax on soft drinks for the eight months' period during the present fiscal year amount to $2,535,686.82, as compared with $2,267,132.64 for the same period last year.

## Chapter of Internal Medicine Society Organized in Parkersburg

A regional chapter of the American Society of Internal Medicine was organized in Parkersburg late in February by specialists in internal medicine located in that city and Point Pleasant.

The Society is composed of recognized specialists in the field of internal medicine who are certified by the American Board of Internal Medicine, or who are Board eligible.

Dr. James L. Wade was elected president, Dr. Andrew C. Woofter, vice president, and Dr. John H. Gile, secretary-treasurer.

The local group will be affiliated with the West Virginia Society of Internal Medicine, which was organized in 1957.

### Auto Emblems Available

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters office in Charleston. The price of each emblem is $3.25 postpaid.

## Trudeau School of Tuberculosis To Conduct PG Course in June

The 45th Session of the Trudeau School of Tuberculosis and Other Pulmonary Diseases will be held at Saranac Lake, New York, June 6-24, 1960.

This postgraduate course, conducted under the auspices of the Trudeau Foundation and supported by the Hyde Foundation, provides instruction at a minimal tuition of $100.00 for the three-weeks' session.

In addition to the local medical faculty consisting of some forty doctors from Saranac Lake, Ray Brook State Tuberculosis Hospital, and Sunmount Veterans Administration Hospital, about thirty of the leading teachers and investigators in the Eastern United States and Canada are brought to Saranac Lake each year to lecture or to conduct seminars in their special fields.

Approximately half of the time is devoted to tuberculosis and the other half is divided between such subjects as silicosis, pulmonary fibrosis, emphysema, fungus infection, sarcoidosis, pneumonias and intrathoracic tumors.

Inquiries concerning the course should be addressed to the Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 500, Saranac Lake, New York.

## Dr. E. M. Best, Jr., Medical Director At Carbide's Technical Center

Dr. Earl M. Best, Jr., of South Charleston, who has served for the past six years as plant physician for Union Carbide, has been named director of the medical department of the company's Technical Center in that city.

# The West Virginia Medical Journal

May, 1960 Vol. 56, No. 5

## Meeting the Challenge to Society*

*E. Lyle Gage, M. D.*

John has been an active, healthy, alert member of his organization busily doing his job and fully participating in the activities of his occupation. For several years he has continued to become more in demand and of greatest importance in performing his duties.

Now gradually things are changing. John is growing older. He bumps into things. His hands seem clumsy, he stumbles into things with his feet, his hair distribution is no longer as it was and his voice has changed. Yes, John is growing older and he has been told that unfortunately he can no longer fill his job and they will have to let him go. What will he do? He has had very little counseling and he does not have Social Security.

You see John is a choir boy and in growing older he has become a clumsy adolescent of thirteen years, who has to shave and whose voice is no longer suitable in a boys' choir. John is an occupational casualty of aging. He is also subject to other effects of the aging process just as are people of 40, 50, or 65 years of age. The difference is that John has the restless bursting, often misunderstood thoughts and actions of adolescence instead of the frustrated hot flashes of the climacteric or the vacant sense of dizziness, defeat and memory loss associated with inadequate cerebral circulation or little strokes.

We doctors have learned to know that as life goes along, each stage has its needs and its compensations. Each period may require some care, supervision and understanding on the part of the individual, his associates and his doctor. But the aging process is a continuous one throughout life.

*Presented before a Regional Conference on Aging, sponsored by the American Medical Association, in Baltimore, March 30-31, 1960.

Submitted to the Publication Committee, April 1, 1960.

### *The Author*

- **E. Lyle Gage, M. D., Chairman, West Virginia State Medical Association's Committee on Aging, Bluefield, W. Va.**

The aged cannot be located and set apart by any certain number of years, for a youth may be old in spirit, while an octogenarian may be alert and animated. True age determination is physiological and not chronological. The law setting up the White House Conference on Aging has set apart our elder citizens chronologically as a group for study and possibly for arrangement of their lives by legislation.

Laws and customs of other times and other lands have also regulated the aged. In the light of enlightened teachings some of these regulations seem heathenish while others seem commendable. How will our customs, family life, regulations and laws appear in the cold light of history? Will forced retirement based on a person's years of age seem just? Will it seem right that we force teachers, executives, master craftsmen and the military personnel to retire at an age when others are just being considered old enough for election to Congress? How will it appear to future generations that in our time old people must have lived on devaluated savings and have been prohibited from continued earning by the threat of losing their Social Security? How will it appear if individuals and families no longer care for their invalid parents but relegate them to the care of the state to be deposited in specially designated institutions like the insane? Will such disposition of the old folks meet the Biblical requirement of "honor thy father and thy mother?"

I believe we can care for our aged people in a manner which will honor them as well as make them happy if we can keep the personal touch, the family touch, and still expand facilities locally to meet occupational, recreational, health and housing needs.

We doctors can help in preparing our younger patients for that time when they are no longer as agile and alert and have been judged aged by their younger contemporaries. What can we do for our patients and ourselves to help during life to prevent or minimize wear and tear?

I believe we can begin by trying to teach the young how to acquire correct personal hygiene, healthy attitudes, love for our fellows and a happy outlook on life. We can also point out that there should be a time for work, a time for rest, and a time for social life and recreation; and that too much devotion to any one of these periods at the expense of the others is unhealthy. We can teach thrift and self-dependence rather than dependence upon others, or upon the state. To do this we will need the aid of parents, teachers, and the clergy. We doctors can teach and practice prophylactic injections and healthy living. We can encourage periodic physical and mental examinations to detect abnormalities early and institute corrective measures when necessary. We can help correct faulty procedures of living by teaching people to assume proper physical and mental behavior patterns.

Much of this we have done. We have helped to prolong life and health by 25 years in this century. Now let us help both individuals and society to utilize and enjoy these additional years. For those who become ill we may help provide a means of care and housing. In my opinion this should be on an individual and local basis so that personal acquaintance and understanding is not lost.

Many churches, clubs, fraternal organizations and civic groups are already helping to provide nursing homes and care for the aged infirm. These groups should be greatly encouraged. They are also providing for crippled children and chronic invalids in earlier life and this is as it should be since illness and disability are found not only after age 65 but at all ages.

Some older people feel elated and flattered that they are being placed in a separate group to receive special consideration at a White House Conference. On the other hand a great many of them do not feel that way about it and they just want to remain a part of America and the human race and to go on about business and recreation as usual as long as they are able. Unfortunately, forced retirement often prevents this.

When forced to retire, some of the aged are not financially able to live comfortably or enjoy many pleasures. Forced retirement has placed a psychological barrier before many otherwise alert active individuals and the effect upon their health and thinking is not beneficial. Forced retirement is on the basis of generalization and chronological age instead of individual potential. Doctors by counseling and suggestion can help many of these retired to recover from the shock of this occupational climacteric. The potential suicide and the sitter can often be activated to attain courage, ambition, and a new life in a new post-retirement field. They can be taught the thrill of the study of nature, of the flowers, the birds, the life cycle of growing things, the sunrise and the sunset. Many haven't had much time to think of these before and a new interest can often be aroused. The help of industry, unions and society in general is earnestly solicited in helping to change our ways so that people will be allowed to produce and create as long as they are able.

When illness comes to the older patient we must take our newest knowledge of Geriatrics to the battle, but we must also keep in mind a lot of common sense and understanding of older people. Abrupt change from the customary routine of life is not tolerated well. It may help an 80-year-old man's morale a great deal to allow him to wear his own long underwear or nightshirt to bed instead of a hospital gown. On the other hand a hearing aid, new glasses, a new set of properly fitting teeth or a manicure and hair dressing can sometimes mean the reawakening of interest in life. When we encounter resistance to treatment and delay in rehabilitation of an older patient we must remember that this reaction may be the result of resentment against man-made barriers against the aged which deny this patient his opportunity to participate in life to the limit of his capacity.

We hear a great deal about people being unable to have medical care as they grow older because of the cost. I am a member of a partnership of forty-five doctors comprising the staffs of three hospitals in Southwest Virginia and West Virginia, and I am not aware of any person who has been denied necessary medical care by anyone in our partnership for financial reasons. However, I am aware of the hardships imposed on some of our people by inflation and the so-called industrial revolution and I should like to propose the following suggestions which might help some of those who are growing older:

(1) The revision of retirement laws, regulations, and practices, so that chronological age will no longer be a criterion for enforced retirement and those who are able can continue to work and earn and produce.

(2) The revision of compensation laws to enable the employer to provide work for older people without placing his business in jeopardy.

(3) The revision of old, or the formation of new tax laws to provide exemption for specified funds placed by a worker in reserve for retirement, medical care, sickness, insurance, and purchase of housing for himself and family.

(4) Until forced retirement based on chronological age is abolished let us have exemption from personal income tax of the first $3,000 per annum for persons 65 years of age and older.

(5) Then could we not have the release of some local and personal taxes by the federal government if the money is used wisely, carefully, and in an efficient manner to care for the aged at the local level?

Health, hospitalization and medical care of the aged comprise but a small part of the problems of our older citizens.

As Kuplan has said, "The basic responsibility for meeting the problems of aging lies with the citizens in each community."

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# Plight of the Nightingales

The demand for nursing hands is tremendous. The major area of need, of course, is within the hospitals of our country, and as more hospital beds are realized for the community, this need is accelerated. The community has use for the hands of the visiting nurse: it is these fine people who bridge the gap, among other things, between the hospitalized patient and the one whose convalescence is completed.

The units of local government which provide medical service likewise place a demand for nursing hands in their system of hospitals and clinics. The office of the doctor of medicine is a better office when a nurse is present.

Then there are the requirements of the employer in industry for the staffing of first aid facilities, in-plant hospitals or dispensaries, and, unfortunately also in the personnel or the insurance office to keep tally on insurance forms.

Set against these is also the great demand of the health arms of the Federal Government, the Public Health Service, the often internally competitive hospital systems of the three armed forces, and the gargantuan hospital program of the Veterans Administration.

What about the source of these nursing hands? For the most part they come from the nursing schools of the private voluntary hospitals of our nation, in lesser degree from the teaching units of our colleges. There is no source of nursing hands from industry, the armed forces or the Veterans Administration to offset the bleeding which they produce from this limited pool.

I would not suggest for a moment that a solution to this might lie in industry's or government's entry into this field of basic nursing training. But industry could well extend itself to underwriting the expansion of our good hospital nursing schools; this would certainly be non-inflationary in a fiscal sense. And government could well take a look at the waste of everything, including nursing hands, in its duplication of health facilities. It might even take a look at the potential of scholarship incentive through our extant nursing schools, and if this could be called "research," there would be limited area for argument—William Bromme, M. D., in Detroit Medical News.

# Whip-Lash Injury: Fact or Fiction*†

*William F. Hillier, Jr., M. D.*

THE term, "whip-lash injury," had its inception in 1953 when an article entitled, "Common Whip-Lash Injuries of the Neck," by Doctors Gay and Abbott, was published in *The Journal of the American Medical Association.* Since then, the medicolegal race has been on. The medical profession, generally, has reason to regret the term, since no other type of injury has caused more physicians, in particular, surgeons, to be called as expert witnesses, either for the plaintiff or the defendant, in the multitudinous lawsuits resulting therefrom. Whereas formerly, injuries of the neck usually were described, respectively, as (1) cervical sprain, (2) fracture of the cervical spine, (3) fracture dislocation of the cervical spine, (4) spinal cord contusion, (5) spinal cord transection, (6) cervical radiculitis, (7) protruded intervertebral disc, or other well-defined clinical syndrome, all now are lumped together under the pleasant legophilic term, "whip-lash injury." This, we gather, as used, distinctly includes injuries of the neck and contents of the cranial cavity.

### Etiology

The injury which we shall discuss usually is caused in the following manner:

The future patient (and probable plaintiff) is sitting in his car at a stop light, when a vehicle approaches from the rear. The driver either does not see that the light is red or, if he does, has faulty brakes, misjudges the distance or miscalculates in one way or another, and manages to strike the car of the "patient" from the rear. The "patient's" body is thrust forward and the head violently hyperextended, then hyperflexed. It has been demonstrated that a 3500 pound car traveling at ten miles per hour may, on striking the rear of another car, transmit to this car a force of twenty-five tons. Thus, with the anatomical relation of the head to the neck, the base of the neck acts as a fulcrum and the leverage is applied near the top of the head. The head, therefore, snaps back with the equivalent of several tons of force and without any support, since the muscle control of the neck is in a relaxed or nonprotective state.

*From the Department of Neurosurgery, Bluefield Sanitarium, Bluefield, W. Va.

†Presented before the annual meeting of the West Virginia Chapter of the American College of Surgeons, at The Greenbrier in White Sulphur Springs, April 3, 1959.

Submitted to the Publication Committee, December 15, 1959.

## *The Author*

- **William F. Hillier, Jr., M. D., Bluefield Sanitarium Clinic, Bluefield, W. Va.**

### Vulnerable Structures in 'Whip-Lash'

Let us now consider the structures which may be injured. By virtue of the atlanto-occipital and atlanto-axial articulations, the neck can tilt forward, backward and sideward, and can rotate. Extremes of movement are held in check by the anterior, posterior and lateral ligaments, as well as by the joint capsule and fibrous tissue about the joints. The dens or odontoid process of the axis is held in position by the aid of the transverse ligament of the atlas. Lying within the foramina transversaria of the cervical vertebrae are the two vertebral arteries. These pass upward through these foramina in the lower six cervical vertebrae, then, after passing through the transverse foramen of the atlas, turn sharply medially and after piercing a thick membrane between the atlas and the occipital bone, enter the cranial cavity through the foramen magnum. There is very little slack in the vertebral arteries so that during severe hyperextension and hyperflexion, and especially during lateral rotation, partial or complete obstruction of the artery may occur. It is well known that intermittent insufficiency of the vertebral basilar system of arteries produces the following signs:

1. Visual dimness.
2. Weakness of the limbs.
3. Dysarthria.
4. Dysphagia.
5. Diplopia.
6. Confusion.
7. Vertigo.

The second cervical nerve emerges between the atlas and the axis, the point of greatest rotation of the head on the neck. It continues as the greater occipital nerve which supplies the cutaneous distribution of the occiput, the side of the neck and, to some degree, the face. It is well recognized that in many cases of occipital neuralgia, the pain is referred to the eye on the involved side and that hemicrania, not dissimilar to migraine, also may occur.

Signs and Symptoms Due to Injury of the Second Cervical Nerve Root:

1. Tenderness over the course of the greater occipital nerve.
2. Diminution of the sense of pain and touch over the back of the head and at times the side of the neck and the lower jaw.
3. Subjective numbness over the occipital region of the scalp.
4. Hemicrania, not unlike that associated with migraine.
5. Pain behind and above the eye on the involved side.

Injuries producing anterior or posterior dislocation of the cervical vertebrae may cause concussion, contusion or, by shearing action, transection of the spinal cord, with resultant paraplegia or tetraplegia, more often the latter, at the cervical level.

With sudden hyperextension and hyperflexion injuries of the neck, the cervical nerves that make up the cervical and brachial plexuses, may be badly contused or even avulsed, resulting in the well-known motor, sensory and reflex changes in the involved arm or arms. In addition, the sympathetic nerve supply may be interfered with, producing true causalgia, i. e., burning, coldness, cramping and the like, in the involved extremity.

Stretching and tearing injuries of the muscles may cause hemorrhage into the muscle bundles and ligaments, with development of muscle spasm and, later, fibrosis and scarring.

Fracture of the vertebral bodies without dislocation and fracture of the spinous and transverse processes also are seen in these injuries, attended by muscle spasm, narrowing of the intervertebral foramina with bleeding about the nerve roots, impingement on the nerve roots, and injury of the joints.

Protrusion of the cervical disc within 18 to 24 months, as a result of a whip-lash injury, occurred in 20 per cent of cases reported by Gay and Abbott. Some observers, including Frankel, believe that symptoms associated with the so-called cervical disc syndrome more often are manifestations of injury of the lateral intervertebral joints which are in contiguity with important nerves and arteries.

To summarize briefly, then, following whip-lash injuries, *symptoms* may arise from:

1. Partial or complete obstruction of the vertebral artery.
2. Stretching or contusion of the second cervical nerve.
3. Radiculitis secondary to contusion and stretching of the cervical nerves.
4. Concussion, contusion, or transection of the spinal cord.
5. Fracture dislocation of the cervical vertebrae.
6. Cervical disc protrusion.

Of what, then, does the patient complain, following a whip-lash injury?

**Symptoms of Whip-Lash Injury**

1. Confusion.
2. Blurring of vision and transient blindness.
3. Severe headache.
4. Severe neck and shoulder pain.
5. Transient weakness of the arms or legs, or both.
6. Difficulty in swallowing and talking.
7. Nausea and vomiting.
8. Dizziness and light-headedness.
9. Occipital pain and pain referred to the eye.

After the initial shock of the injury, many times the patient will state to the police and others that he is perfectly well, often waving aside suggestions for hospital examination or treatment, only to appear at the hospital several days or weeks later with several or perhaps many of the above-listed symptoms.

How, then, can such a case be evaluated properly?

**For Proper Evaluation of the Case**

1. Careful history.
2. Careful physical and neurological examinations.
   a. cranial nerves.
   b. flexion, extension and rotation of neck.
   c. palpation over greater occipital nerve.
   d. motor, sensory and reflex functions of upper and lower extremities.
   e. cardiac function, with electrocardiogram if indicated.
3. Lumbar puncture in cases with neurological deficit.
4. Myelography, if indicated by results of neurological and spinal fluid examinations, and by x-rays.
5. X-rays of the cervical spine: AP, PA, right and left, oblique, open mouth view to show odontoid process, and lateral films in flexion and extension.
6. X-rays of the skull which should include AP, PA, right and left lateral.
7. Eye, ear, nose and throat consultation, if indicated.

With such painstaking evaluation plus accurate and detailed records of the results, the physician usually can establish the diagnosis with little difficulty and can treat the patient intelligently. In addition, his careful records will stand him in good stead if litigation follows at a later date (and it probably will).

In the majority of these cases, the following pathologic conditions usually are ruled out early:

1. Spinal cord concussion, contusion, or transection.
2. Fracture of cervical vertebrae.
3. Protruded intervertebral disc, cervical.
4. Injuries of brachial or cervical plexuses.
5. Brain concussion, contusion, or hematoma.

We therefore are left with the person who has the following complaints or findings:

a. Dizziness and nausea, particularly on change of position.
b. Headache, particularly occipital in location.
c. Limitation, perhaps, of one or another movement of the neck.
d. "Popping" in the neck
e. Soreness over the scapular areas.
f. Tenderness over the greater occipital nerve on one side.
g. Nervousness, "jitteriness," weakness and emotionalism.

The x-rays of the skull and cervical spine are negative, or there is some osteoarthritis which has been present for some time, though the patient may be easily convinced that it came on as a result of the accident. His lumbar puncture and spinal fluid studies usually are normal. His electrocardiogram and electroencephalogram are normal, and his general physical examination is very much normal, so then, most of his symptoms, medically and legally, are subjective (a delicate point of view with juries, I have discovered, is the subtle difference between subjective and objective).

The patient with the least in the way of positive objective findings, probably is the patient to whom we pay the least attention and probably is the one who most needs our help. Lest we too rapidly pass off a person as psychoneurotic, a malingerer, or a litigation candidate, perhaps we should consider ourselves the passenger or driver in the car which has been struck and with the present-day accident rate, we very well may be.

**Treatment**

A. Preventive:
   1. Seat belts.
   2. Shoulder belts.
   3. Neck extension to back of front seat.
   4. Driver education.
   5. Reduction of horsepower of automobiles.

B. Therapy:
   1. Traction: halter type of cervical traction, using 7-15 pounds intermittently.
   2. Wet or dry heat to neck.
   3. Massage.
   4. Oral or injectable relaxants.
   5. Analgesics.
   6. Operative intervention if clearly indicated.
   7. Reassurance and encouragement.
   8. Psychotherapy.

Different patients may require different methods of treatment but the foregoing table would embrace most of the methods used in treatment of the "whip-lash" type of injury.

**Litigation**

In October 1956, an article by Dr. Nicholas Gotten of Memphis, Tennessee, appeared in *The Journal of the American Medical Association*. In his conclusions, Doctor Gotten reported that in the study of some 100 patients with a whip-lash type of injury, interviewed subsequent to settlement of legal claims for damage, 88 per cent had recovered, 54 with no residual, 34 with minor symptoms, not requiring therapy. Twelve per cent continued to have symptoms but only 6 per cent of these were under medical treatment. Surgery was necessary in only two cases. Psychosomatic symptoms were manifested in some way in 85 per cent of cases.

There was loss of time for as long as three months in 41 per cent of cases before settlement of claims and in 7 per cent subsequent to settlement.

It was concluded that the evidence indicated the great difficulty in evaluating the whip-lash type of injury because of the complicating factors imposed by monetary compensation. No large series of cases as yet has been analyzed, to my knowledge, but indications are that the American Academy of Orthopedic Surgery will present a symposium some time in 1960 on the subject, from which may be gained valuable data compiled from the experience of many, to the benefit of surgeons handling this type of case.

It is my opinion that each case should be judged entirely on its own merits. A careful history, examination and laboratory studies should aid us in an accurate diagnosis. Thoughtful and patient therapy will help in many instances. Accurate records stand us in good stead if litigation does arise, and it becomes increasingly apparent that more and more of these cases end up in court. It was estimated in a recent book by Marvin Belli that 85 per cent of all cases in the court today are civil suits. These, then, represent the bulk of the court's work and so very many are accident cases that we, as surgeons, must realize that our work no longer ends with treatment of the patient for his medical ills; instead, it involves concern with his economic welfare, his loss of earning power, his inability to work, and his disability rate. The same Marvin Belli, in his book, "Ready for the Plaintiff," makes clearly evident the trend towards higher awards for the plaintiff. Since the competent and honest surgeon, like the competent and honest lawyer, wishes to see justice done, he should be ready to aid counsel, either for the plaintiff or the defense, by carefully recorded case histories and by conscientious ap-

praisal of the disability, if such exists. His answers to questions in court should be accurate, yet couched in terms that laymen can understand. The use of anatomical diagrams, with simple explanations of medical terms, is much appreciated by jury and judge alike. Only as we are willing to serve justice in this way will our patients be properly and honestly served, both medically and legally, and perhaps, in so doing, we can persuade our legal brothers to abandon the term, "whip-lash," for one more scientifically descriptive, such as "hyperextension-hyperflexion injury of the neck" or, at least, one that is less theatrical and more specifically descriptive of what actually has happened to the patient.

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# Medicine and Society

Modern life is full of threats to health as menacing as the earlier excrescences of industrialization. The air is poisoned, foods denatured, and men and women subjected to intolerable psychic pressures. And Americans nevertheless felicitate themselves on their vast hospitals, their complex schemes of medical insurance and the massive expenditures devoted to the repair of shattered bodies and minds.

The social services of the modern state are, like its medical services, frequently invoked to remedy conditions that should never have been allowed to arise. Having packed people into cities, one calls on the community to entertain them; having made them parts of a system that cannot take responsibility for providing continuous jobs, one looks to the Government for props and compensations.

The nineteenth century saw a great movement toward sanitation. May not the twentieth century, before it is through, see a great movement toward simplification of life, toward a restoration of conditions that seem at the same time closer to real happiness and to real health? The relation between the two remain largely in the field of the unknown, but that they are related one feels in one's bones.

And so while Americans congratulate themselves on what they have achieved to improve the health of the people, to find cures and to develop treatments, they should not forget—doctors and laymen alike—the great work of social reformation that underlies medicine as it underlies politics. Science is at the heart of the problem, but beyond science there are the qualities of human living and of a sane environment that scientists and philosophers have sought together since the rise of civilization. The quest continues. All are summoned to do their part.—August Heckscher in New England Journal of Medicine.

# Sub-Lethal Attacks of Amniotic Fluid Embolism

## (Case Report)

*Theo H. Boysen, III, M. D.*

### Purpose

It is the purpose of this paper to review the subject of amniotic fluid embolism and present again the non-fatal or sub-lethal aspects of this obstetrical catastrophe as shown by a representative case.


### *The Author*

- **Theo H. Boysen, III, M. D., Director, Division of Maternal and Child Health, State Department of Health, Charleston, W. Va.**


### Historical Background[1,2,3]

Steiner and Lushbaugh, in 1941, described for the first time the entity of amniotic fluid embolism. Their report included eight cases. In addition, they produced experimentally a similar clinicopathologic picture in dogs and rabbits by the intravenous injection of suspension of particulate matter obtained from amniotic fluid. They also suggested the possibility of non-fatal embolic attacks from the same source.

It was not until December 1947, however, that Seltzer and Schuman published the first report of a non-fatal case of pulmonary embolism from amniotic fluid.

### Clinical Course

Overwhelming shock occurring suddenly in a woman in hard labor or immediately after delivery, with no obvious cause (i. e., ruptured uterus, massive hemorrhage), is the usual picture. A fall in blood pressure, absence of radial pulsation, restlessness, anxiety, a feeling of impending danger, cyanosis, dyspnea, then death, occur in rapid succession. If death is delayed, profuse postpartum hemorrhage based on fibrinogenopenia occurs.

### Mechanism[4,5,6]

Several factors must be present in the pathogenesis of this phenomenon. There must be trapped fluid under pressure and a means of entrance into the maternal circulation. The fluid enters the abnormally opened sinusoids as in rupture of the uterus, premature separation of the placenta, marginal clot, caesarean section or any tear or surgical incision into the uterus, endocervix, cervix or placenta present.

The fluid is trapped because the membranes are not ruptured at the cervix or because the fetal head blocks the escape of fluid via the cervix. More often than not, there is an overdistended uterus as in the case of a large baby or multiple babies. The contractions are violent, often tetanic, and always harder than normal. Most of the cases are associated with blood in the amniotic fluid before the onset of labor and it is conceivable that retroplacental hemorrhage is the cause of the violent contractions.

Submitted to the Publication Committee, October 30, 1959.

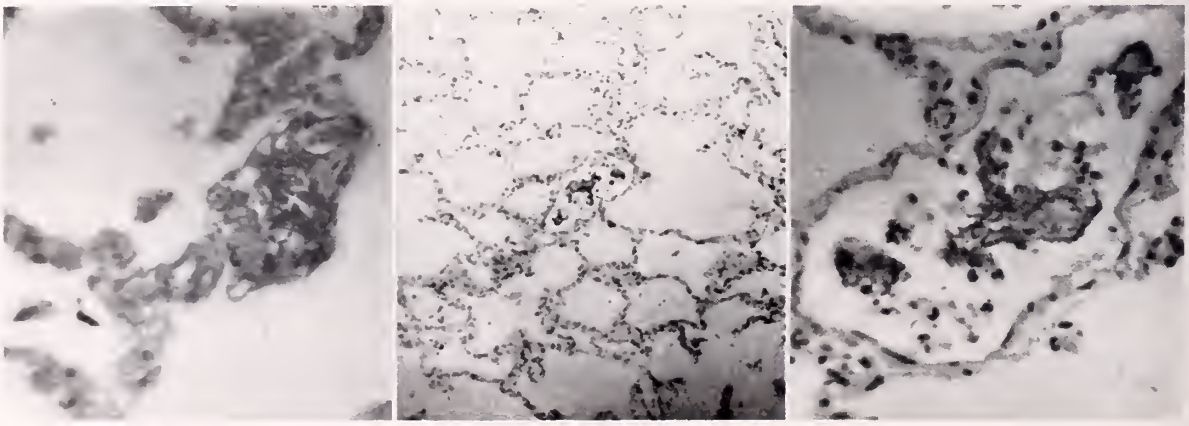

Figure 1

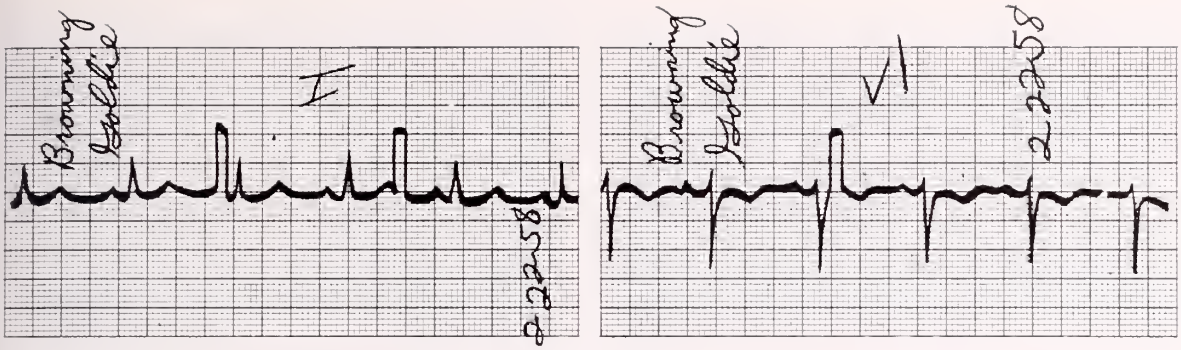


Figure 2

**Pathology**[1,5,6,7,8,9,10,11]

Amniotic fluid embolism is a pathologic diagnosis based on certain observations at autopsy. The essential findings are limited to the lungs and pleural cavities. The lungs are edematous and the pleural cavities may contain varying amounts of clear fluid. Microscopically many pulmonary arterioles from 1 mm. in diameter down to capillaries are distended greatly, have thinned walls and are occluded by foreign material consisting of squamous epithelial debris, amorphous material, mucin from meconium, bile pigment, lanugo and leukocytes. The material stains blue with the Bauer-Feulgen stain for acid mucopolysaccharide. With the hematoxylin-eosin method, the amorphous granular fetal squames stain pink.

Grossly, the cut surface of the lung shows numerous areas of amniotic and meconium emboli. Droplets of glistening yellow material can be expressed from the arterioles on the cut surface. Smears of the material show lanugo and debris.

**Additional Diagnostic Aid**[9,12]

If permission for autopsy is refused, blood can be drawn from the right side of the heart or from the vena cava and centrifuged. Instead of a layer of cells with a clear layer above it, there are three layers. When an amniotic fluid embolism has occurred, there is a broad, more flocculent zone of lighter color above the thin gray layer of leukocytic cream. The floating elements can be recovered from the surface of the serum and the remaining amniotic debris from the top of the leukocytic cream immediately under the serum layer. Proper staining of this material will reveal the elements from the amniotic fluid.

In sub-lethal cases, PA and lateral chest films, if successive and serial, will reveal various degrees of infiltration, i. e., increased densities, which usually clear up more rapidly than do those due to pneumonitis *per se*.

The electrocardiogram may show an inverted T wave in lead 2, and this may mean localized ischemia.

**Treatment**[3]

When amniotic fluid embolism is suspected, continuous oxygen, either intranasally or via oxygen tent, should be started. Morphine should be given for restlessness, and papaverine given intravenously to relieve vascular spasm. Atropine grains 1/50 should be given for drying effect. It is important not to overload the circulation and thus aggravate existing pulmonary edema. No intravenous fluids, therefore, should be given. Whole blood may be necessary when there is obvious blood loss, but it must be given with great care. The use of multiple tourniquets as suggested by Seltzer and Schuman[3] may be of value.

If fibrinogenopenia is present, as determined by the inability of 5-10 cc's. of blood to clot within 3 to 5 minutes, fibrinogen should be given and the initial dose should be 3 Gm.

**Case Report**

G. B., a 35-year-old white housewife, was a gravida 5, para 3, abortions 1. She had her menarche at age 15 and continued regular, every 28 days, lasting 3 to 4 days. Her LMP was June 28-30, making her EDC April 5, 1958. She registered at the Prenatal Clinic of Man Memorial Hospital, November 29, 1957, and was seen on four other occasions before admission. Her past history, other than a D & C in 1948 after a 10-month (?) stillborn, and another in 1956 after an 8-week spontaneous abortion, was noncontributory. Physical examination was within normal limits for a 26-week gestation. Blood pressure and weight gain were normal. She was group A, Rh positive; D, positive; C, negative; E, positive. VDRL was negative. Urinalysis was within normal limits.

At 1 A. M., February 22, 1958, the patient came to the emergency ward complaining of a sudden onset of numbness all over, also of dyspnea, at approximately 4 P. M. the previous day,

while reading. When seen, she was acutely dyspneic and slightly cyanotic. B. P. 144/96, respiration 43, pulse 92, temperature 97.6 F. There was pitting edema (plus 4) of legs. Breath sounds were increased, with a few crepitant rales at the left base.

Initial blood count showed hemoglobin 12 Gm., WBC 9,650, with a normal differential. Urine was unobtainable until 9 A. M., when a catheterized specimen was found to be loaded with RBC, contained a few WBC, and albumen (2 plus). The $CO_2$ combining power was 13.5 mEq., chlorides 120.2 mEq., potassium 4.6 mEq., sodium 134 mEq. NPN was 16.5 mg. The respiratory rate at this time was 36-40 per minute. The patient was dyspneic but did not appear ill. The fundus measured 38 cm. above the symphysis. The face was flushed, and there was a slight, generalized, red rash over the skin of the abdomen.

E. K. G.

| | |
|---|---|
| Atrial rate | 80 |
| Ventricular rate | 80 |
| P. R. interval | 0.18 |
| Rhythm | Reg. S. R. |
| Q. R. S. | 0.08 |
| Q. T. | 0.39-0.40 |
| Axis deviation | No |

"Q. T. is at upper limits of normal or slightly above normal, suggesting electrolyte imbalance. Above inverted T wave may mean localized ischemia. Will admit it may occasionally be seen in cases of embolism."

From the time of admission until 1:30 P. M., the patient had passed only one ounce of urine. At 1:30 P. M., by catheterization, 200 cc's. were obtained. Repeat PA and lateral chest films (Figure 4) again revealed infiltration in the left base posteriorly, with slight progression since those taken at 2:30 A. M. (Figure 3).

At this time (1:30 P. M.), the patient exhibited a generalized rash resembling a sulfonamide rash. Respirations were still 40 per minute. The rash disappeared at 3 P. M. From that time on her condition improved. Her output was normal, the edema less, the respiration rate normal, and the chest clear to percussion and auscultation. Catheterized and voided urine ranged from none to a trace of albumen, with an occasional RBC.

On February 23, 1958, a repeat PA and lateral of the chest (Figure 5) showed resolving of the infiltration seen before.

On February 27, 1958, the patient had slight contractions. At 6 A. M. she began very active labor and in 30 minutes was completely dilated. Under spinal anesthesia and with low forceps, after performing a left midline episiotomy, living female twins weighing 5 lbs., 3 oz. and 4 lbs., 5 oz., respectively, were delivered. The placenta delivered spontaneously and completely, and was of a bi-zygotic twin type.

The patient had a normal postpartum course. Repeat EKG on March 3 was reported as "T wave inversion in $V_2$ had disappeared and all T waves are taller."

| | |
|---|---|
| Atrial rate | 68 |
| Ventricular rate | 68 |
| Regular sinus rhythm | |

"Since there was a transient T wave inversion in right precordial lead noted shortly after patient's acute illness, it is possible that pulmonary embolism or infarction was present."

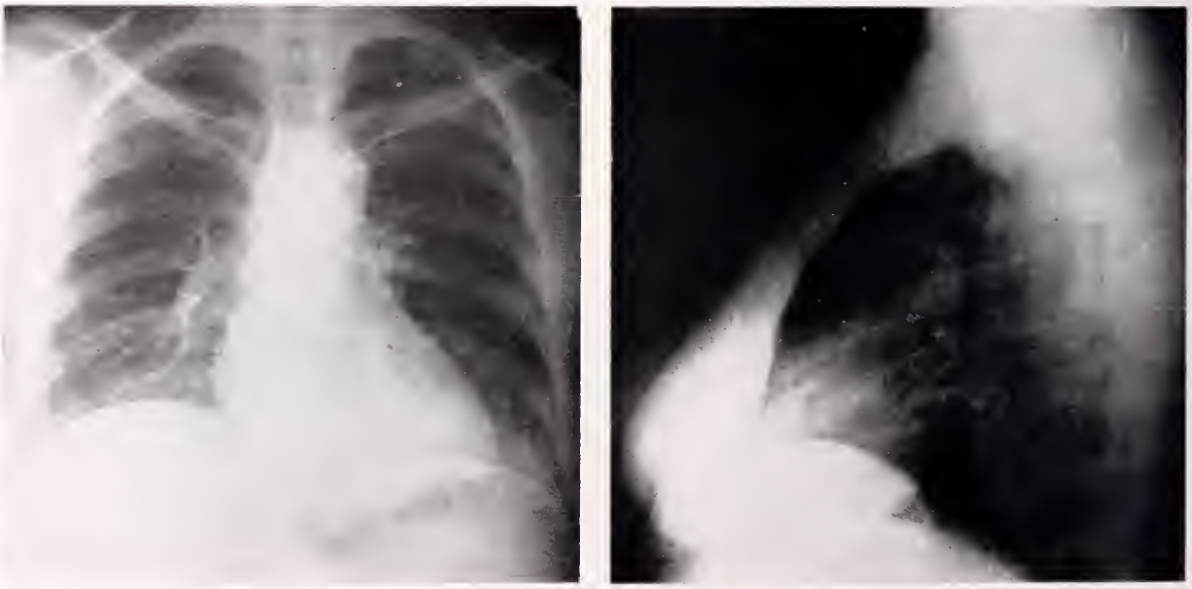

Figure 3

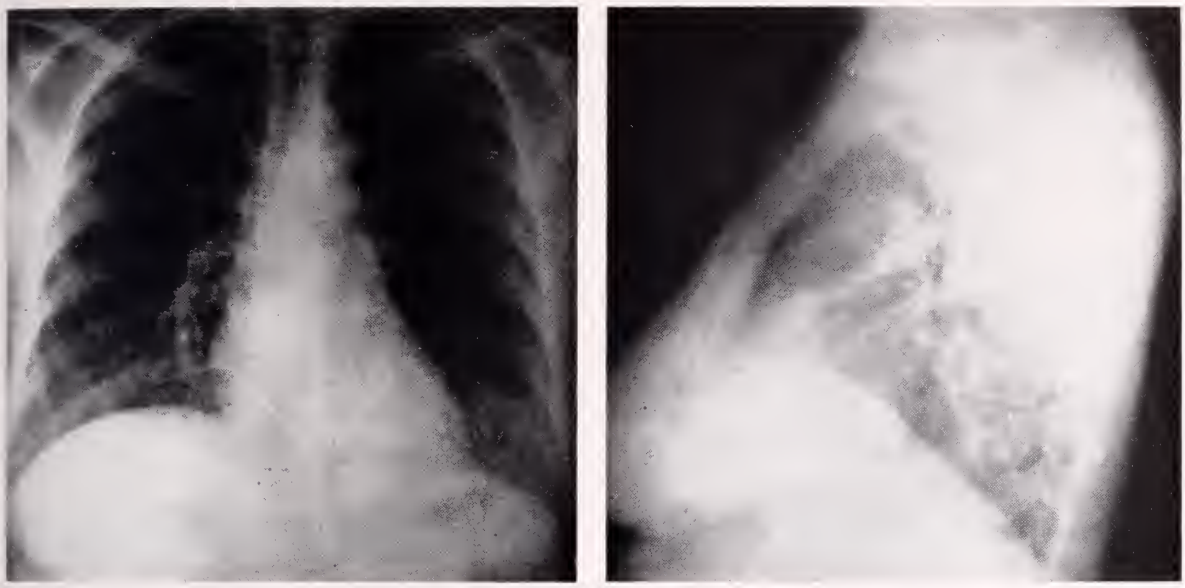

Figure 4

Postpartum urinalysis was normal, as was the blood count.

Repeat PA and lateral of the chest (Figure 7) this date was reported as "Upright PA and lateral views of the chest were compared with similar chest radiographs made February 22, 1958 and February 23, 1958, and show complete clearing of the infiltration which was previously present in the left base posteriorly. This localized area of infiltration could well have been on the basis of some embolic phenomena. The possibility of it being pneumonitis which has subsequently cleared cannot be ruled out by the x-ray examination alone."

She was discharged on March 5, and appeared for her six weeks postpartum checkup April 15, 1958. She had no complaints. Physical examination was normal for the six week state, and she was placed on a three month follow-up.

### Summary

The subject of amniotic fluid embolism has been rather fully reviewed. The matter of sublethal attacks of such type of embolism has again been presented along with the report of a case strongly suggestive of the condition in that the multiparous uterus was overdistended with a twin pregnancy, although the membranes were intact and there was no labor. The onset was

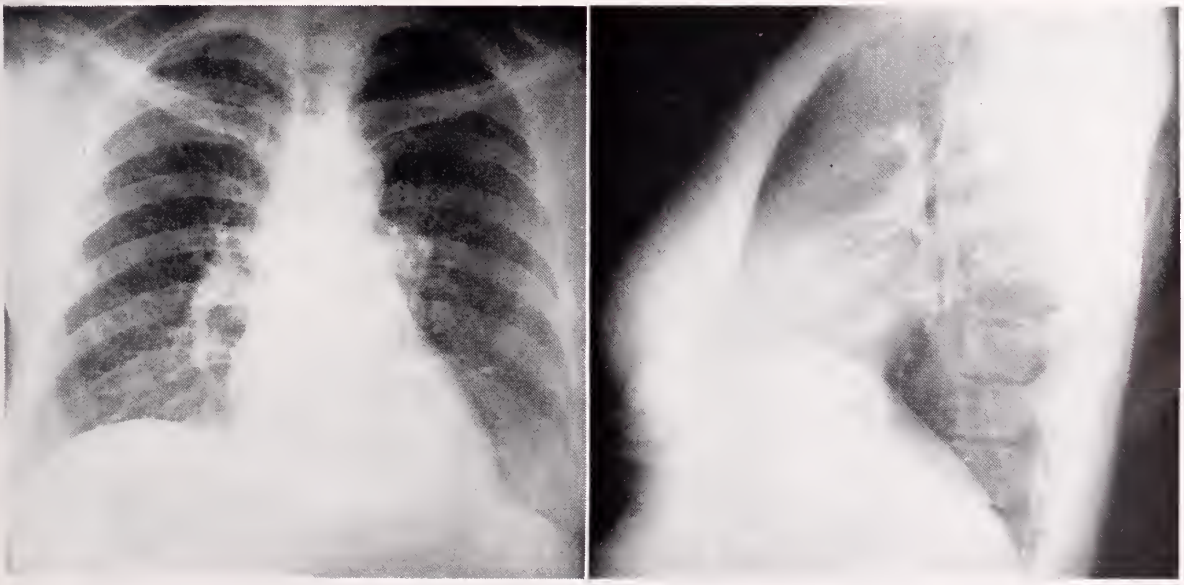

Figure 5

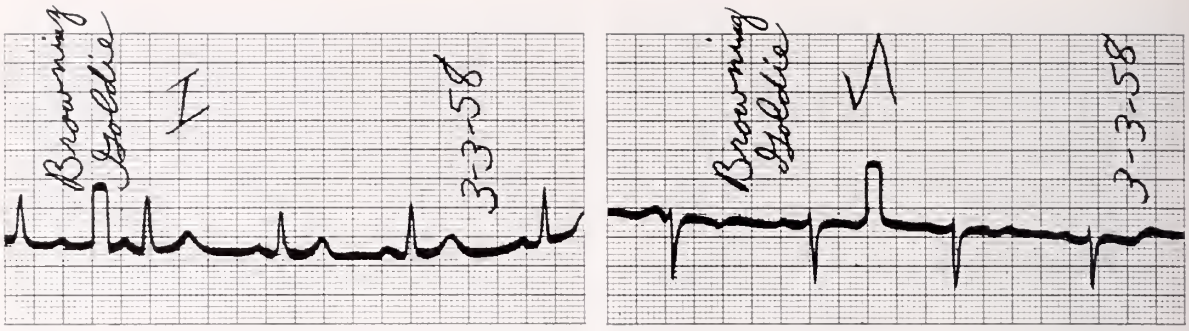


Figure 6

sudden and dramatic. Dyspnea was severe. There was a foreign protein rash. There was transient anuria and transient hematuria, plus roentgen evidence of infiltration in the left base with clearance. EKG changes compatible with embolism or infarction were noted.


### Acknowledgments

The case report was presented through the courtesy of Man Memorial Hospital, Man, West Virginia, where, at that time, the author was Chief of Obstetrics and Gynecology.

The pathological slides used in the paper were reproduced through the courtesy of the Armed Forces Institute of Pathology, Washington, D. C.


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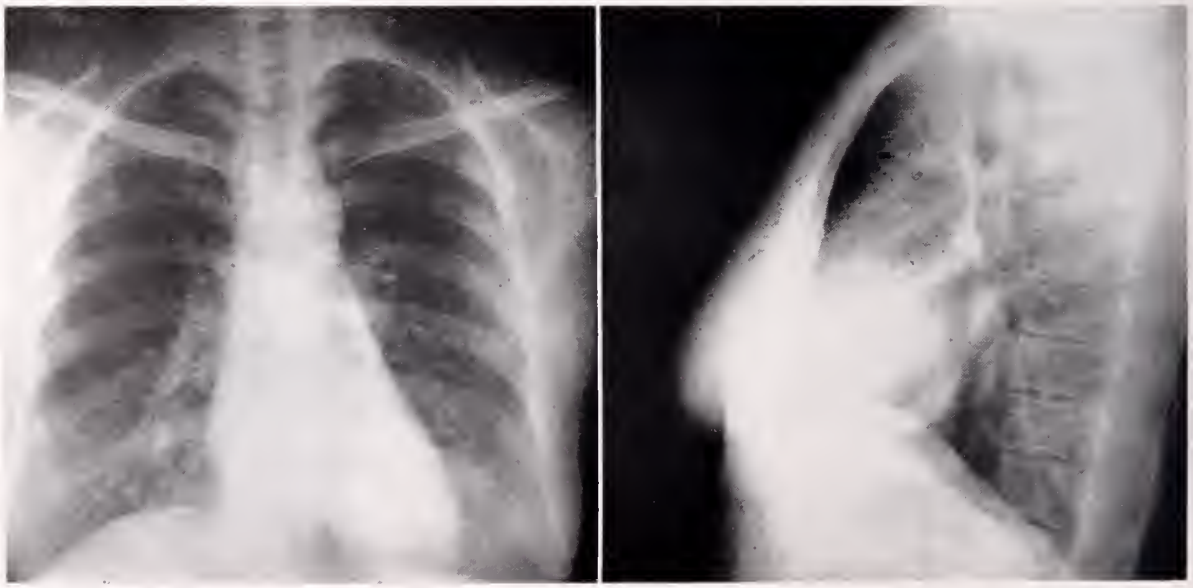

Figure 7

# Missed Hernia: A Cause of Recurrence*

*Samir Shabb, M. D., and Bert Bradford, Jr., M. D.*

FAILURE to identify the hernia sac at surgery is a frequent cause of recurrence. Most of the published articles dealing with recurrence of inguinal and femoral hernias stress the importance of technique and the advantages of the different methods of repair.

The records of 445 inguinal and 26 femoral hernia cases in which operation was performed in Memorial Hospital over a three-year period were carefully reviewed in an effort to discover the cause of recurrence.

There was a total of 26 recurrences, of which 22 were inguinal and four femoral. Sixteen, or 72 per cent, of the inguinal recurrences were indirect, occurring at the internal inguinal ring; five, or 22.7 per cent, were direct, coming out through Hesselbach's triangle or directly next to the pubic spine; one, or 4.6 per cent, was undetermined.

Of the femoral hernias, 3 occurred in females and one in a male. All four patients were over 51 years of age, the oldest being 80. Of the inguinal recurrences, all but one occurred in males. The youngest of these patients was a boy aged 9 years, the oldest being 68 years of age. If the 9-year-old boy were excluded, the average age would be 50.7 years.

### Type of Recurrence

Two of the femoral hernias recurred a few days after the initial repair, one a few months afterward, and one five and one-half years after the original operation. All of the initial repairs had been for inguinal hernia. It appears obvious that the femoral hernia was present and overlooked in at least three of the four patients. Eight, or 36.3 per cent, of the inguinal recurrences took place less than eight months after the initial repair, and only 3 occurred more than five years afterward. There were three cases in which the time of recurrence was undetermined.

### Types of Repair

Two of the femoral hernias were repaired through the inguinal route, and two below the inguinal ligament. Of the inguinal hernias, 19 were repaired by the Halstead method of transplanting the cord beneath the skin.

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Submitted to the Publication Committee, October 24, 1959.

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### Discussion

The causes of recurrent hernia are many and varied, and it is not within the scope of this paper to list them all. The papers that really emphasize the great importance of the missed hernia, however, are few.[5, 8] This is especially true with regard to recurrent femoral hernia. Some authors believe that femoral hernia develops after inguinal repair because of the tension placed on the inguinal ligament. The femoral canal gets wider and, therefore, hernia is more likely to develop.[3] Ryan believes that occurrence of the femoral hernia after an inguinal repair is because of a missed hernia at the time of operation. He offers as proof the fact that of six recurrences, five took place within one month after the initial repair.[6, 8] Other common causes of recurrence are incomplete removal of the sac and, in a certain per cent of cases, the existence of more than one sac.[6, 8]

Although the present series is small, it is interesting to note that of the 26 recurrences, four, or 15.4 per cent, were femoral. In all four instances, repair of an inguinal hernia had been done previously. In two of the four cases, recurrence appeared within a few days after the procedure, in one case, within a few months following initial repair, and in one case several (five and one-half) years later. It is evident that the first three hernias were missed. The operation records in two of these cases were reviewed and in spite of the fact that the patients gave a history of large hernias, no definite sac was encountered in the areas explored (internal ring and floor of canal) and repair for a so-called direct hernia was performed.

There was one other case in which repair for direct inguinal hernia was performed three months previously, with subsequent development of a large, indirect, inguinal hernia.

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FORCE INJURY
severe bruises
. . . swelling
. . . cleared
by fifth day[2]

VARICOSE
ULCER
15 years duration
. . . resolved with
VARIDASE[1]

INFLAMMATORY
DERMATOSIS
rapidly spreading
rhus dermatitis
healed within
a week[1]

INFECTED
LACERATION
marked reversal
in 3 days . . .
returned
to school . . .
losure advanced[1]

THROMBOPHLEBITIS
back on his feet
in a week after
recurrent episode[1]

REFRACTORY
CELLULITIS
normal routine
resumed after 4 days
of VARIDASE[1]

There were four proven instances of missed hernia as a cause of recurrence, comprising 15.4 per cent of the total number of recurrences, which is quite significant. We believe that a thorough search of all the usual sites of hernia, such as the internal ring, floor of canal, and femoral canal, should be made during a routine herniorrhaphy. It is especially important in adults and in those cases in which a doubtful sac is found, and in the presence of definite clinical findings of a large hernia. Such a routine undoubtedly would reduce the incidence of recurrence.


**Summary**

Case records of 471 inguinal and femoral hernias were reviewed. There were 26 recurrences noted, of which four were femoral hernia. Three femoral recurrences and one inguinal recurrence, or 15.4 per cent, were distinctly thought to be caused by a missed sac at the time of the initial procedure. A thorough search of all the usual sites of hernia should be made at the time of routine herniorrhaphy.


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# Bolstering Self-Respect

Problems associated with the aging individual are at present receiving a great deal of attention throughout the country. It is all too common that a man is forced by regulation to give up his life work at the age of sixty-five or thereabouts regardless of his capabilities.

There is no sound reason to assume that a person becomes inefficient at that age or any specific age. One can hardly claim that President Eisenhower, Winston Churchill and our own senior senator, Theodore Francis Green, ceased developing at the age of sixty-five. You may well say these men are exceptional individuals. They are, but day in and day out we see people over the usual retirement age who have a keenness of vision and grasp of their subject far superior to that of their juniors and even to their own at an earlier age. They are a healthy and stabilizing influence in their fields of activity.

Perhaps even worse than a forced retirement age is the general prejudice against hiring any but young people to fill vacancies in all sorts of employment. People who are denied the privilege of working when able tend to lose their sense of wellbeing, are a serious economic drain on society, an unnecessary waste of one of our greatest national recources, trained manpower, and finally they tend to deteriorate mentally and physically.

Self-respect is a very important thing to every individual and collectively to every group no matter how large or small. Self-respect is hardly available without accomplishment. Many older people can accomplish much more than they are accomplishing if given the proper guidance and encouragement. They are much better off and happier if they are doing for themselves than if all is done for them.—John C. Ham, M. D., in Rhode Island Medical Journal.

# Histoplasmosis*

*James H. Matthews, M. D.*

The title assigned to this paper gives me considerable opportunity to select the subject for this discussion. Histoplasmosis is a disease interesting from many aspects. The history of the development of our knowledge of histoplasmosis is fascinating. It has occurred largely during our lifetime and much of it has been accomplished during our professional careers and by our close friends and associates. The epidemiology of histoplasmosis is equally exciting and is important to a satisfactory understanding of the disease. The geographic distribution is such that the incidence of exposure to Histoplasma capsulatum is relatively high in the areas covered by this Chapter, whereas it is quite low in Western North Carolina. Many of our patients have come from the states comprising the Potomac Chapter.

The laboratory aspects including mycology, serology and pathology would be fruitful for discussion. None of these shall I attempt to discuss today; instead, I shall present briefly some of the clinical manifestations of histoplasmosis which we have observed during the past several years. I wish to mention only in passing the generalized disseminated disease in which myriads of Histoplasma capsulatum are found throughout the reticuloendothelial system. This is the form of the disease which was first known and is widely recognized as a clinical entity. I shall also only mention the ulcerative lesions which have been demonstrated in the buccal and pharyngeal areas, and shall concentrate on the pulmonary manifestations as being of special interest to chest physicians and surgeons.

### Pulmonary Manifestations

We have recognized six different types of pulmonary manifestations which we consider to have resulted from H. capsulatum infection. These are not entirely distinct entities but their recognition is valuable from diagnostic and treatment viewpoints.

Pleural effusion was observed in a young man who had consistently negative tuberculin tests, positive histoplasmin skin test, and positive complement fixation tests with histoplasma whole yeast antigen as well as with histoplasmin antigen. The effusion subsided spontaneously and was considered probably to have been a manifestation of histoplasmosis. It is entirely possible that we have treated other histoplasmosis patients with pleural effusion which was attributed to tuberculosis. It is of interest in this respect that Billings and Couch,[1] of Nashville, have reported two cases of pericardial calcification which they attributed to histoplasmosis.

Bilateral disseminated pulmonary calcification is seen not infrequently in patients from endemic areas. Careful studies have demonstrated adequately that this is practically diagnostic of healed diffuse pulmonary histoplasmosis.

We have observed five patients with a third type of pulmonary lesion which is the acute diffuse pulmonary disease. This is believed to be the acute form of the disease which eventually results in the bilateral disseminated calcification and which is caused by massive inhalation of histoplasma-laden dust. One of our patients was seen shortly after he acquired the disease on cleaning his chicken house in Christiansburg, Virginia, in 1952. Six years later his x-ray showed definite diffuse calcification.

There was another young man who lived in North Carolina in an area in which the disease is not endemic and who apparently acquired the infection on a frog gigging expedition while vacationing in central Kentucky. His disease was less acute. A third patient who was quite ill also had cleaned out a chicken house one week prior to the onset of his acute illness. He also demonstrated very extensive pulmonary involvement. The fourth patient, whom we saw only in the convalescent phase of his illness, obviously had acquired his infection when he left his east Kentucky home and worked for the Park Service in Columbus, Ohio. Both he and a fellow worker became acutely ill shortly after they


## *The Author*

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***Presented before the annual meeting of the Potomac Chapter of the American College of Chest Physicians, at The Greenbrier in White Sulphur Springs, October 9, 1959.**

**Submitted to the Publication Committee, November 4, 1959.**

had shoveled dirt in a greenhouse from which tulip bulbs had been transplanted.

The fifth patient had a less extensive lesion and the origin of his infection was unknown. It is of interest that another member of his family previously had had established histoplasmosis. Clinically he was mildly ill with fever and malaise. Radiographically his lesions presented more as multiple nodular lesions and it was suspected at first that these might be metastatic tumors until the lesions began to resolve on nonspecific treatment at bed rest coincident with the disappearance of his clinical symptoms. This patient had a sarcoid type reaction in scalene lymph node, positive histoplasmin skin test and high titer complement fixation and positive colloidal agglutination tests to the histoplasmin antigen as well as cross reaction with blastomycin and coccidiodin antigens.

These patients with acute diffuse pulmonary disease often are acutely ill, with high fever, and the condition may be mistaken for severe tuberculous infection. In these cases, H. capsulatum can be isolated from the sputum, in the acute phase. The patients we have seen with this type of disease have recovered without specific treatment, and one has been followed now for over six years without further illness. In one case, there did appear to be dramatic improvement after the patient was given sulfadiazine, but this may have been coincidence.

The fourth type of pulmonary histoplasmosis which we have seen is the granuloma or histoplasmoma. Patients with this manifestation present with a so-called "coin lesion." A differential diagnosis between tumors and granuloma often can not be made without excision. Once a granuloma has been demonstrated by microscopic study, a differential diagnosis must be made as to etiology, considering at least tuberculosis, histoplasmosis and brucellosis. Special stains such as periodic acid Schiff and Gomori methenamine silver often will demonstrate organisms which most students on the subject accept as H. capsulatum. In caseous tissues these organisms tend to be larger than those usually seen in other tissues, but they have been cultured and demonstrated to be typical histoplasma organisms. In the majority of histoplasmomata the organisms are apparently not viable; at least we have generally been unable to culture them.

The fifth type of lesion has been seen in several patients who have had pulmonary infiltrations, positive histoplasmin skin tests, and positive complement fixation tests for histoplasma antigens. These are difficult to differentiate from typical tuberculosis, especially when tuberculin tests also are positive. One such patient seen at our hospital was observed and released with a tentative diagnosis of histoplasmosis. He returned 15 months later with evidence of progression of disease by x-ray, and H. capsulatum were cultured from sputum and bronchial washings. In a similar case, in which H. capsulatum were detected from gastric wash, the patient was followed for several years. His disease ran a relatively benign but protracted course.

The final pulmonary manifestation is one that is of considerable interest to pulmonary disease specialists, particularly surgeons, and one that either is occuring more frequently or is being recognized more often. This is the chronic cavitary disease in which the sputum is readily positive for H. capsulatum. There are currently three patients in our hospital with this type of histoplasmosis. One, a psychotic, elderly negro, has shown clinical improvement on bed rest but no change by x-ray. His sputum remains readily positive for histoplasma. No further treatment is contemplated because of the psychosis and his asymptomatic status. A second patient has just completed an extensive treatment with amphotericin-B, with clinical improvement and sputum conversion. His large cavities persist although his sputum is presently negative. He is not suitable, because of his age and extensive Marie-Strumpell type of arthritis, for pulmonary resection. It will be of interest to determine whether "open negative cavity" designation will also be applicable in histoplasmosis as it has been recently in tuberculosis. The third patient has just recently been started on treatment with amphotericin-B. His disease is quite extensive.

Six other patients of this type have been observed at Oteen VAH. One had a concomitant infection with Friedlander's bacillus. This patient was successfully treated with an uncomplicated lobectomy. Two of the six patients had concomitant active pulmonary tuberculosis. One of these improved and became negative both for tubercle bacilli and H. capsulatum on treatment with bed rest, INH and PAS. The other five patients have been treated with pulmonary resection or thoracoplasty, or both. The patient who received only a thoracoplasty was chronically ill with other diseases which prevented consideration of pulmonary resection. His sputum became negative for H. capsulatum following the thoracoplasty.

It has not been my purpose to discuss in detail the therapy of histoplasmosis, although certain

aspects of treatment have been discussed in connection with each type of manifestation noted. Currently, amphotericin-B appears to be the most effective anti-fungal drug available, but it is too early to evaluate definitely its long-range effectiveness in this chronic disease. While this drug is being studied, it would be worthwhile perhaps to defer resection of residual lesions and even residual cavities if the sputum is negative for H. capsulatum. Only by long-term observation of these patients can we ever adequately evaluate the effectiveness of this drug.

**Summary**

In summary, I have attempted to discuss briefly some of the varied manifestations of pulmonary histoplasmosis. It is my opinion that H. capsulatum can cause any type of radiographic lesion in the lung that the tubercle bacillus can, and perhaps an even greater variety of disease than is seen with tuberculosis. Histoplasmosis is certainly an important disease to consider in a differential diagnosis of pulmonary disease.

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# Smugness, Sepsis and Syphilis

It seems to be in the cards—or maybe in the stars—that as soon as we make a solid advance in medical science, and we sit down to pat ourselves on the back, some little gremlin comes along and tells us that there is no cause for congratulations. Not so long ago we were anticipating the elimination of syphilis. We became less vigilant. Now for the first time in many decades, the syphilis infection rate is beginning to rise.

The triumph of the antibiotics is still a proper subject for praise. However, germs are now being born which seem to have a built-in resistance. Our search for newer antibiotics reminds one of the eternal quest for stronger and stronger armor plate as the munition makers develop more and more powerful bullets.

The most recent example of the effect of our smugness is the development of anxiety about hospital sepsis. For half a century we have watched with great self-satisfaction the lessening toll from puerperal sepsis, wound infections and infectious gangrene. While we thus became increasingly complacent about hospital infection, we also developed some degree of boldness in the scope, speed, casualness and number of our surgical operations. To accommodate the increasing tempo of the operating room, we streamlined numerous hospital practices. Instead of depending on technical niceties, we began to depend on anti-infective preparations. We expected that the fight against sepsis would be done in a push-button fashion.

Now we realize that no infection can be considered "minor." Now we are faced with problems of hospital epidemiology and infectious control that must make Semmelweiss and Lister chuckle.

The moral is plain and written in letters so large that he who runs may read. The battle against disease and death is never won and eternal vigilance is the price of health. We may feel proud of our achievements but there is a difference between pride and complacency. There can be no holiday in the endless struggle against infection, disorder and death itself.—Journal, Medical Society of New Jersey.

# Intestinal Obstruction Secondary to Shredded Cocoanut*

## (Case Report)

*James E. Boggs, M. D., James P. Eaton, M. D., and John T. Jarrett, M. D.*

The first reported case of intestinal obstruction secondary to cocoanut fibers was published by Quain, in 1854. Since then, five cases of intestinal obstruction in which cocoanut fibers were listed as the etiologic agent have been reported.[1] One of these was similar to ours in that the "cocoanut ileus" followed subtotal gastrectomy.[2]

### Case Report

A 42-year-old white woman was admitted to Charleston Memorial Hospital complaining of generalized abdominal pain, also nausea and vomiting, of 17 hours' duration. The vomitus was described as containing undigested food and some green bile-appearing liquid. It was noticed by the intern shortly after admission that the vomitus contained a large amount of corn; there was no evidence of blood. There had been no bowel movement nor passage of flatus since onset. There had been no previous similar episodes.

The past history was noncontributory except for subtotal gastrectomy in 1956 for an "intractable" duodenal ulcer.

Physical examination revealed a poorly developed, undernourished, white woman who appeared acutely ill and in considerable pain. Oral temperature 98.8 F., pulse 84, respiration 20, blood pressure 105/80.

The patient was edentulous.

Examination of the abdomen revealed moderate distention and generalized tenderness. There was no rebound tenderness or muscle spasm.

Bowel sounds were hyperactive and an occasional high-pitched tinkle was heard. The remainder of the physical examination was noncontributory.

The admission white blood count was 17,450, with 89 per cent polymorphnuclear neutrophils and 4 per cent bands. The hematocrit was 41 vol. per cent. Urinalysis showed pH of 6.0, specific gravity 1.025, negative for sugar and albumin. There were 5 to 10 WBC and 1 to 3 RBC per HPF.

*From the Surgical Service, Memorial Hospital, Charleston, West Virginia.

Submitted to the Publication Committee, October 24, 1959.


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X-rays of the chest and abdomen were normal on admission. Repeat upright and recumbent films of the abdomen 28 hours after admission showed distended loops of jejunum and proximal ileum, suggesting partial intestinal obstruction (Figure 1).

The patient was taken to surgery approximately 29 hours after admission, with a preoperative diagnosis of mechanical small bowel obstruction. Upon entering the peritoneal cavity,

**Figure 1. Dilated loops of small bowel.**

straw-colored fluid was encountered as well as moderately dilated loops of small bowel. At a point about 8 inches proximal to the ileocecal valve, the area of dilated bowel suddenly ended and collapsed small bowel was present distally. At this transitional area, there was a firm, intraluminal, obstructing 4 x 7 cm. mass. A longitudinal incision was made over the mass and a bolus of cocoanut and whole grain corn was removed. Approximately 90 per cent of the bezoar consisted of shredded cocoanut (Figure 2). The enterotomy was closed in transverse fashion. The patient had an uneventful postoperative course.

**Figure 2. Cross section of cocoanut bezoar.**

On further questioning after operation, the patient stated that approximately 36 hours prior to admission she had eaten two handfuls of shredded cocoanut, and that four hours later she had eaten a large amount of whole grain corn.

### Discussion

Etiologically, bezoars are divided into two large groups: the phytobezoar, composed of vegetable fibers, and the trichobezoar, composed of hair. Elliot,[3] in 1932, reported his observations in a review of 39 cases of bolus obstruction of the intestine. In the majority of cases, obstruction was caused by ingested persimmons. He reported also a fatal case of intestinal obstruction due to ingested oranges.

De Bakey and Ochsner,[4] in a review of 311 cases, found that in 172 cases the obstructing agent was a trichobezoar, in 126 a phytobezoar, and in the remaining 13 cases the obstruction was caused by a concretion. Of the 126 phytobezoars, 92 consisted of persimmons. Of the 172 trichobezoars, 91.4 per cent occurred in females, whereas 77 per cent of the phytobezoars occurred in males.

There were several conditions considered as predisposing factors in this type of intestinal obstruction: (1) previous surgery, with resultant adhesion bands, (2) increased age, with an atonic digestive tract, (3) stricture or neoplasm, (4) absence of teeth, (5) drinking of a large quantity of water with meal, resulting in swelling of vegetable fibers, with consequent increased bulk sufficient to cause obstruction and (6) the habit of swallowing food whole.

In the case presented, at least three of the above-mentioned predisposing factors were present: (1) edentulous state, (2) habit of swallowing food whole, secondary to edentulous state and (3) previous subtotal gastrectomy. The obstruction occurred in the terminal ileum, the most frequent site of that due to food bolus.

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*. . . one learns to itch where one can scratch.*

Ernest Bramah.

# The President's Page

## A Medical Benevolence Fund

Our concern with the subject of care of the aging has unearthed some heretofore little known facts about needy medical men and their families. I have been assembling some material on this subject. Consequently, I was struck by the following news brief which appeared in the February 1, 1960 issue of *Medical Economics*:

"Indigency among M.D's is less rare than many medical men think, a recent check by this magazine indicates. In six states alone, medical societies last year gave $180,000 in aid to some 240 destitute doctors. Explained one medical leader: " 'I'm convinced that more indigency would be found among doctors, but too often needy doctors are too proud to expose their indigency' "

Many others are living in genteel poverty on retirement incomes once believed adequate. Others, struck down by illness, have had their working productive years cut short. Sons and daughters have run into difficulty acquiring an education. Widows have needed help.

Economists tell us that increased taxes are bound to come from additional defense spending, increased social security costs, and the gradual but inevitable rise in the cost of living with the subsequent devaluation of the dollar. Building an estate becomes more and more difficult. We must be realistic and have enough foresight to set up a program to care for these doctors who have given so generously of themselves. Many states have already done this, and have now built up adequate funds. It seems to me West Virginia should fall in line.

One of the first to formulate a plan was our neighboring state of Pennsylvania. We can learn much from study of her problems and how she solved them by what she has called "The Medical Benevolence Fund." In stating the purpose of this program of "beneficence with compassion," it says the fund is established:

"To be used for the relief of pecuniary distress of sick or aged active and associate members, or the parents, widows, widowers or children of deceased active or associate members; and for the relief of pecuniary distress of active and associate members resulting from catastrophic natural emergencies. The fund is supported by an annual deduction of $3.00 from the dues of active members and contributions from other sources."

These have included generous gifts from the medical auxiliaries, both state and county. Memorial gifts have added greatly. Bequests in wills have been another factor. Helping our own has become more and more appealing.

Once set up, active cooperation of the component societies is essential. Needs must be reported and a local sponsor, willing to spend time, tact and patience, must be selected. He evaluates the applicant's financial status, and re-evaluates it every six months, all confidentially. Checks are then mailed directly to the individual, except in cases where he is neither physically nor mentally capable.

This, in its simplest essence, is one plan that has worked long and well, with modifications as needed. It would be my suggestion that the West Virginia State Medical Association lose no more time in establishing its own program to care for similar situations. Then it can be shown that we care for our own.

J. C. Huffman, M. D., President

# THE WEST VIRGINIA MEDICAL JOURNAL

*Official Organ of the West Virginia State Medical Association*

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.



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*Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.*

*Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.*


# EDITORIALS

**WHIP-LASH INJURY**

Elsewhere in this issue is an article on so-called "Whip-Lash Injury." As pointed out, this ingenious term has come to be used erroneously as a diagnosis rather than as the description of a mechanism of injury. The term calls to mind the snap of the old fashioned buggywhip and the manner in which the snapper was frayed and shredded. To viewers of television, it recalls the snap of the bullwhip and the stagewhip in the "Westerns," and the implications are frightening. To those raised in the country, where hardy persons still occasionally seize a snake by the tail and snap its head off with a whip-lash motion, the possibility of such injury seems horrible.

People whose minds conjure up visions of such happenings, when the term whip-lash is mentioned, are on juries and must try to reach a just decision in cases of neck injury brought before them in litigation.

Persons of good will and honest intent have sometimes warned patients excessively of the dire possibilities of "Whip-Lash" injury, and as a result, some of these patients have been frightened beyond reason. Other patients have, because of a too carefree attitude, gone about their business with severe injuries which have later produced invalidism. Such is the danger of using a euphonious diagnosis, like whip-lash injury, based upon the mechanism of cause, rather than a meticulous, accurate diagnosis based upon the resultant pathologic effect.

If the term whip-lash is to be used, let us diagnose the resultant abnormality *due to* whip-lash mechanism and not describe the result as a "Whip-Lash Injury."

**THE FORAND FOLLY**

The American medical care industry is one of the most efficient industries in the United States. Dr. Frank G. Dickinson, Ph.D., a leading analyst of medical care in this country, recently published a report in which he stated that the past quarter-century has been the most progressive in the history of medicine and that progress has been achieved "at reasonable cost to the patient."

Contrary to what many "liberals" say, the quantity and Quality of American medical care is of the highest order. Moreover, consumer price indexes indicated, as Doctor Dickinson has noted, "that a given quantity of medical care that would have required an entire week's wages in 1935-39 required only about one-half of a week's wages in 1954." And despite implications to the contrary by welfare-statists, data published by the Department of Commerce indicate that the average income of physicians has increased at almost the same rate as the average income of all gainfully employed people since 1929.

This dynamic progress in medical care is threatened, however, by schemes for the gradual socialization of American medicine. The immediate threat is the Forand Bill, a measure under which Big Government would become responsible for the medical care of persons eligible to receive social security payments.

This bill, of course, is rightly regarded as the first step in the socialization of American medicine. Ultimately, the "liberals" look to complete government control of all medical facilities, precisely as the Social Security law had a small beginning and gradually widened to include practically all income-earners in the country.

While the Forand Bill has plenty of propagandists in Congress and the "liberal" press, very little is said about the cost of the program. When the matter of cost is discussed at all, the backers of the Forand Bill merely refer questioners to the initial payroll tax of a quarter of one per cent for worker and employer, as if that would be the only cost.

Actually, the beginning tax rate for the Forand Bill would not bring in enough money to cover the extremely conservative estimate of $1,100,000,000 made by the Department of Health, Education and Welfare. Statisticians of private business have determined, on the basis of the experience of insurance companies, that the cost in the first year would be twice as much as the government has estimated.

Whatever tax would be required to pay the very heavy costs of the program would have to be added to the already considerable rate for Social Security. At the present time, without the medical care program to pay for, the payroll tax under the Social Security law is 3 per cent each on the employee and employer. By the end of this decade, it will rise to 4½ per cent.

The Forand Bill completely overlooks the healthy growth of private medical care plans, in which there is no danger of government control of medicine or the evils of bureaucracy, high cost and deteriorating quality of service. Tremendous numbers of Americans quite obviously prefer to make their own arrangements for medical care rather than be saddled with a government program they must pay for in taxes. The Forand Bill also ignores the reality of private and public welfare in hundreds of American communities and the generous gift of services which thousands of physicians make in free clinics and to patients who lack the means to pay medical fees. The Forand Bill, then, would strike at charitable efforts and voluntary plans to deal with sickness.

The Forand proposal is one fraught with dangers for medical science. Where the government enters, there freedom for science is lessened. Furthermore, such a bill would inevitably lead to a situation in which a patient would be unable to choose his doctor but would have to accept a government-assigned medical man. These matters aside, it would be prohibitively expensive—a real burden on the long-suffering American taxpayer.

To enact the Forand Bill into law would be to ignore the tremendous progress made by the private medical care industry and to endanger its dynamic growth when a break-through against many diseases is in the offing. Citizens who care for their own health and the health of the nation's economy should urge their Congressmen to defeat the Forand Bill.—*Thurman Sensing, Executive Vice President, Southern States Industrial Council.*

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## THE LONG VIEW OF BLUE SHIELD

If you aren't too sure just what Blue Shield means to medicine, and to you and me, then try to imagine what the economics and the sociology of medical practice would be like without Blue Shield.

Remember first that most Blue Shield Plans were organized by local units of organized medicine 15 or 20 years ago. Medicine then faced an urgent popular demand for some mechanism through which people could prepay unpredictable medical care costs. The insurance companies doubted that medical bills could be safely covered by insurance methods; and the politicians and social reformers were openly skeptical that doctors and patients would ever be able to get together voluntarily on any workable prepayment plan.

For the first time in modern history, America's physicians, aided and abetted by free labor, free industry and the genius of American free enterprise, solved a complex nation-wide social problem by voluntary action.

Blue Shield is the one prepayment plan exclusively devoted to the mutual interests of patient and doctor. It is "nonprofit," which is to say that the profits belong to the subscriber.

Blue Shield is the greatest contribution American medicine has ever made in the medico-economic sphere, and it is dedicated to the preservation of a system of medical care that both the profession and the people of this country clearly want to preserve.

# GENERAL NEWS

## Medical-Dental Liaison Committee Approved by Council

The Council of the West Virginia State Medical Association has gone on record as reaffirming the "West Virginia Standard Code of Necropsy or Autopsy Procedure" which has been in effect since April 1, 1951. This action was taken at the spring meeting held at the Daniel Boone Hotel in Charleston, March 19-20,

The Council accepted the recommendation of a committee composed of representatives of the State Medical Association, the West Virginia Funeral Directors Association, the Association of Pathologists of West Virginia and the West Virginia Hospital Association, and it is expected that the other three groups will also officially reaffirm the Code, which will then be reprinted as of July 1, 1960.

The joint committee held a meeting in Charleston on February 24 and went on record unanimously as approving the reprinting of the existing Code without change. That meeting was attended by Dr. Russel Kessel of Charleston, representing the State Medical Association; H. Eugene Merrill of Parkersburg, R. Doyle Fidler of Belle, Harold Beard of Huntington, and Elwood G. Grisell of Moundsville, the Funeral Directors Association; William R. Huff and Harvey McMillan both of Charleston, the Hospital Association; and Drs. M. L. Hobbs of Morgantown and David F. Bell, Jr., of Bluefield, the Association of Pathologists.

### Medical-Dental Liaison Committee

In another action taken by the Council with a view to establishing closer relations with members of the dental profession in this state, unanimous approval was given to the creation of a joint liaison committee between the State Medical Association and the West Virginia State Dental Society.

(Subsequently, at a meeting of the Executive Council of the State Dental Society held in Parkersburg on March 27, the creation of a liaison committee was approved).

### Honorary Members Elected

The following physicians were elected to honorary life membership in the State Medical Association:

| *Society* | *Physician* | *Address* |
|---|---|---|
| Harrison | H. Allen Whisler | Clarksburg |
| | Eugene B. Wright | Clarksburg |
| Kanawha | G. G. Irwin | Charleston |
| | R. E. Woodall | Coral Gables, Fla. |
| Mingo | Henry Clay Hays | Williamson |
| Monongalia | H. V. King | Morgantown |
| Parkersburg | Rush C. Newman | Spencer |

### Stand Against Forand Bill Reaffirmed

The Council went on record unanimously as reaffirming its opposition to the enactment by Congress of any Forand-type legislation.

### Committee Report

Reports were made by the chairmen of the following key committees of the Association:

Aging, Dr. E. Lyle Gage of Bluefield; Medical Economics, Dr. James S. Klumpp of Huntington; DPA and Workmen's Compensation (sub-committee of Committee on Medical Economics), Dr. John E. Lutz of Charleston; and Legislative, Dr. Frank J. Holroyd of Princeton.

The entire DPA program in West Virginia was reviewed and discussed by Mr. Thomas R. Egbert, Director of the State Department of Public Assistance.

### Medical Examiner's System Again Approved

The Council again went on record unanimously in favor of the enactment of legislation establishing a Medical Examiner's System in West Virginia.

The meeting was attended by Dr. George F. Evans, Clarksburg, Chairman; Dr. Charles A. Hoffman, Huntington, Councillor at Large; Dr. J. C. Huffman, Buckhannon, President; Dr. John W. Hash, Charleston, President Elect; Dr. D. N. Barber, Charleston, Treasurer; and Drs. Richard E. Flood, Weirton, S. Elizabeth McFetridge, Shepherdstown, J. C. Pickett, Morgantown, L. E. Neal, Clarksburg, C. R. Davisson, Weston, Charles L. Goodhand, Parkersburg, A. C. Esposito, Huntington, L. J. Pace, Princeton, Harold Van Hoose, Man, William L. Cooke, Charleston, and Clyde A. Smith, Beckley; and Mr. William H. Lively, Executive Assistant of Charleston.

The meeting was also attended by Dr. James S. Klumpp of Huntington, parliamentarian and chairman of the Medical Economics Committee; Dr. Walter E. Vest of Huntington, editor of The Journal; Dr. Frank J. Holroyd of Princeton, AMA Delegate and chairman of the Legislative Committee; Dr. Thomas G. Reed of Charleston, Alternate AMA Delegate; Mr. William E. Mohler of Charleston, legal counsel; Mr. J. Harold Laughlin of Charleston, president of the West Virginia Hospital Association; Mr. Thomas R. Egbert of Charleston, director, State Department of Public Assistance; Dr. John E. Lutz of Charleston, member of the Medical Economics Committee; Dr. Frank V. Langfitt of Clarksburg, member of the Legislative Committee and a past president of the State Medical Association; Dr. Carl B.

Hall of Charleston, past president of the Kanawha Medical Society; and Drs. W. Parke Johnson, Jr., and Donald P. Brown, both of Kingwood.

## Medical-Dental Groups Create Joint Liaison Committee

A joint liaison committee between the West Virginia State Medical Association and the West Virginia State Dental Society was created in April following approval by the Councils of the two organizations.

Dr. J. C. Huffman of Buckhannon, president of the State Medical Association, has appointed the following physicians as members of the joint committee:

Dr. Edward F. Heiskell, Jr., of Morgantown, Dr. Clyde Litton of Charleston, and Dr. Andrew J. Weaver of Clarksburg.

The following dentists have been appointed members of the committee by Dr. Clarence C. Cottrill, president of the State Dental Society:

Dr. G. N. Casto, Jr., and Dr. Wilbur C. Moorman, both of Charleston, and Dr. Kenneth V. Randolph of Morgantown, Dean of the West Virginia University School of Dentistry.

## Summer Camp for Epileptic Children

The Federal Association for Epilepsy has announced that the second annual summer camp program for children with epilepsy will open on June 6 at the National Childrens Rehabilitation Center at Leesburg, Virginia.

Applications for admission for children between the ages of 7 and 12, from all parts of the country, are now being accepted. Children will be admitted for periods ranging from two weeks up to the duration of the summer.

Fees for the camp program are based upon each family's financial situation. Further information may be obtained by writing to Dr. Charles Kram, Director, Federal Association for Epilepsy, Inc., 1729 F Street, N. W., Washington 6, D. C.

## Film on 'Resuscitation of the Newborn'

A new film on "Resuscitation of the Newborn," the first in a series of medical teaching films to be produced semi-annually by Smith Kline and French Laboratories, is now available for showings before county medical society meetings.

The 16 mm sound film, made under the medical direction of the Special Committee on Infant Mortality of the Medical Society of New York County, illustrates essential techniques and principles for the resuscitation of infants who do not breathe, or whose breathing is impaired, at birth.

Prints of the film may be obtained by writing to Smith Kline and French Medical Film Center, 1530 Spring Garden Street, Philadelphia 1, Pennsylvania.

## Plans Completed for Program Honoring Dr. Edward J. Van Liere

Plans have been completed for a special program at the West Virginia University Medical Center on May 12 honoring retiring Dean Edward J. Van Liere. Dr. Thomas L. Harris of Parkersburg, president of the West Virginia University Board of Governors, will preside at the meeting which will begin at 2 o'clock in the auditoruim of the WVU Medical Center.

Guests and representatives of various professional groups throughout the state will be present. These will include Dr. J. C. Huffman of Buckhannon, president of the West Virginia State Medical Association, Dr. N. H. Dyer, State Director of Health, and Dr. D. Z. Morgan, president of the Monongalia County Medical Society.

Dean Kenneth V. Randolph of the WVU School of Dentistry, Dean J. L. Hayman of the School of Pharmacy, Dean A. R. Collett of the College of Arts and Sciences, and Dr. J. M. Slack of the School of Medicine will represent their respective University groups. Mr. F. A. Goad, second-year student in the School of Medicine, will represent the medical student body.

The two guest speakers on the scientific program will be Dr. Carl J. Wiggers of Cleveland, Ohio, and Dr. David Bruce Dill of the Army Medical Center in Maryland. They will be introduced by Dr. F. R. Whittlesey, assistant professor of medicine, and Dr. Kenneth E. Penrod, vice president—medical affairs.

Following the scientific program, there will be a special presentation to Dean Van Liere by Dr. John W. Hash of Charleston, president of the Alumni Association of the School of Medicine.

Presentation of the portrait of the Dean, painted by Mrs. Homer Clark of Boston, will be made by Dr. C. E. Johnson, instructor in medicine, and President Elvis J. Stahr, Jr., will accept the portrait for the University.

A reception in the Faculty Lounge of the Medical Center will conclude the program honoring Doctor Van Liere.

## Revised Booklet on Congenital Cardiac Defects Available

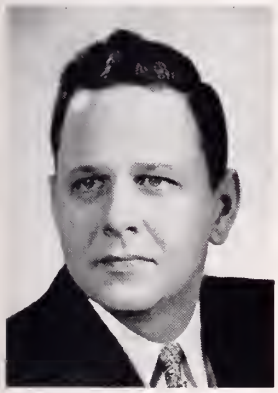
The American Heart Association's booklet for the practicing physician on evaluation and management of congenital cardiac defects has been revised and is available from local Heart Associations and the West Virginia Heart Association under the new title, "Evaluation and Management of Congenital Cardiac Defects." It was formerly titled, "Congenital Cardiac Defects, a Physician's Guide for Evaluation and Management."

Intended to help the physician determine when referral to a cardiologist is required, the 32-page booklet has been substantially revised and expanded to keep pace with the rapid advance in surgical treatment of congenital heart defects. In addition, a new section has been added on Cardiac Defects Amenable to Surgery, which lists some of the signs associated with such defects.

## Plans Nearing Completion for Annual Meeting at The Greenbrier

Another native West Virginian has accepted an invitation to appear as a guest speaker at the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

Dr. Roger B. Scott, prominent obstetrician and gynecologist of Cleveland, Ohio, will present a paper at the third general scientific session on Saturday morning, August 27. He is Associate Professor of



Roger B. Scott, M. D.

Edward M. Litin, M. D.

Obstetrics and Gynecology at Western Reserve University School of Medicine, and Associate Obstetrician and Gynecologist, University Hospitals of Cleveland.

### Native of Moundsville

Dr. Scott was born in Moundsville, West Virginia, and was graduated from West Virginia University in 1934. He received an M. S. degree from the two-year WVU School of Medicine in 1936, and his M. D. degree from Johns Hopkins University School of Medicine in 1938.

He took additional training at Johns Hopkins Hospital, 1938-44, and served in the Medical Corps of the United States Navy, 1944-46. He entered private practice in Baltimore following his discharge from the Navy and also served as gynecologist at Johns Hopkins Hospital until he left that city in 1950 to accept a teaching position with the Western Reserve University School of Medicine and University Hospitals in Cleveland.

Doctor Scott is the author of numerous scientific articles and he has served since 1952 as an Associate Examiner of the American Board of Obstetrics and Gynecology.

### Mayo Staff Member To Speak

Another distinguished speaker will be Dr. Edward M. Litin of Rochester, Minnesota, consultant in the Section of Psychiatry at the Mayo Clinic. He will also appear on the program at the third general session on Saturday morning, August 27.

Doctor Litin is a native of Minneapolis, Minnesota, and was graduated from the University of Minnesota. He received his M. D. degree from the University of Minnesota Medical School, and an M.S. degree in psychiatry from the same school.

He served his internship at the University of Utah in Salt Lake City, 1945-46, and then served for three years as a Captain in the Medical Corps of the United States Army. He became affiliated with the Mayo Clinic in 1948.

Dr. Seigle W. Parks of Fairmont, the chairman of the Program Committee, announced that plans have been completed for the overall scientific program at the meeting. Arrangements are now being worked out for section meetings which will be held afternoons during the three-day meeting.

The Program Committee has already announced that two of the honor guests at the meeting will be Dr. E. Vincent Askey of Los Angeles, California, who will be installed as president of the American Medical Association in June, and Dr. Charles B. Jolliffe, Vice President and Technical Director of the Radio Corporation of America. Doctor Jolliffe is a native of Mannington, West Virginia.

Further details concerning the annual meeting will appear in future issues of *The Journal.* The complete program will be published in the Convention Number in August.

## Tri-County Medical Meeting In Morgantown, May 26

The Annual Tri-County Medical Meeting will be held in Morgantown on May 26. The scientific session in the morning will be presented by the Cornell group, and the subject for discussion will be automobile accidents.

A tour of the Medical School and Teaching Hospital is planned for the afternoon, after which there will be a golf tournament at Lakeview Country Club.

There will be a social hour late in the afternoon, after which dinner will be served at the Club. Dr. Kenneth E. Penrod, Vice President-Medical Affairs, will be the guest speaker.

## Heavy Advance Reservations For the Annual Meeting

Reservations of accommodations at The Greenbrier in connection with the Annual Meeting of the West Virginia State Medical Association, August 25-27, are running well ahead of this same period last year. At the present time, reservations have been made for more than 300 guests.

As usual, many out-of-state physicians will attend this meeting, which always draws heavily from among members of the medical profession, especially in adjoining states.

We would suggest that all members of the West Virginia State Medical Association and Auxiliary book accommodations without delay. Applications for reservations should be made directly to the Reservation Manager, The Greenbrier, White Sulphur Springs.

## Physicians on Duty 24 Hours a Day During Holden Mine Disaster

Members of the Logan County Medical Society were among the hundreds of persons who participated in the heroic, but futile rescue operations carried on in connection with the tragic disaster that took the lives of 18 men in a coal mine near Holden, West Virginia, early in March.

The disaster at Holden Mine Number 22 had its beginning on March 8 shortly after the work-day had begun for the men working on the morning shift. A short time after the men entered the mine a fire was discovered about two miles from the shaft, and 20 miners were trapped behind a wall of fire and smoke.

Members of the Logan County Medical Society were on duty 24 hours a day at the scene of the disaster at Holden Mine Number 22 which took the lives of 18 men. Doctors worked four-hour shifts on an around-the-clock basis during the eight-day period. Shown above are Dr. Ray M. Kessel, president of the Society, and Dr. Mark S. Spurlock, both of Logan. (Photo courtesy of The Logan Banner).

Miraculously, two of the men escaped from the mine through an unused passageway. The other 18 elected to remain in the mine and wait for help from the outside.

Thus began a week-long period filled one moment with hope and the next with frustration. Adverse conditions within the mine continuously threw up insurmountable barriers before the courageous men of the rescue teams.

The impact of the disaster was felt far beyond the boundaries of Logan County and West Virginia. Persons throughout the country followed the hour-by-hour search by means of thorough coverage by the mass press-radio-TV media.

It was to no avail, as it was not until 175 hours after the fire broke out that the first body was found. Mine officials expressed the belief that all had died during the first day as a result of smoke and deathly gas fumes.

Physicians were among the many who had immediately associated themselves with the rescue effort. Fellow miners worked 24 hours a day frantically trying to reach the men they hoped to find alive.

Shortly after news of the trapped men in Holden Mine Number 22 had been relayed throughout the county, members of the Society hastily established a "Holden Disaster Committee" and teams of physicians were organized to remain near the mine entrance on an around-the-clock basis. General practitioners and specialists voluntarily responded to the call of the committee.

They also expressed frequently their willingness to enter the mine to render necessary medical assistance. As it turned out, however, this necessity did not develop.

Physicians did administer medical treatment to the large number of men who worked with the rescue teams during the eight days and nights. They also treated members of families of the trapped miners who maintained a vigil at the entrance.

This care included medication to combat the excessive fatigue of the rescue workers, suturing lacerations and treating cases of carbon monoxide poisoning.

## Drs. Gage and Kessel Attend AMA Meeting in Chicago

Dr. E. Lyle Gage of Bluefield and Dr. C. Royal Kessel of Ripley attended a special meeting sponsored by the American Medical Association to discuss "Preparations for Medicine's Participation in the 1961 White House Conference on Aging."

Doctor Gage, a past president of the West Virginia State Medical Association and chairman of the Committee on Aging, and Doctor Kessel, vice chairman of the West Virginia Commission on Problems of the Aging, represented the State Medical Association at the meeting which was held at AMA Headquarters in Chicago, April 22-23.

Dr. Frederick C. Swartz of Lansing, Michigan, chairman of the AMA Committee on Aging, presided at the two-day meeting which was attended by physicians from throughout the country.

### Relocations

Dr. Marion E. Ingram of Elkins has moved to Buckhannon where he will be associated in general practice with Dr. Wease L. Ashworth, with offices at 10 North Kanawha Street.

* * * *

Dr. Michael M. Stump of Ceredo has accepted a four-year residency in pathology at Texas Medical Center, Baylor University in Houston, effective April 1, 1960.

* * * *

Dr. David E. Yoho of Moundsville has accepted a residency in anesthesiology at Mercy Hospital in Pittsburgh.

## West Virginia Physicians Attend AAGP Meeting in Philadelphia

Dr. Floyd C. Bratt of Rochester, New York, was named president elect of the American Academy of General Practice during the 12th annual Scientific Assembly in Philadelphia, March 21-24. He will be installed as president at the 1961 meeting in Miami Beach, Florida, succeeding Dr. John G. Walsh of Sacramento, California, who will serve as president during the coming year.

Floyd C. Bratt, M. D.

Doctor Bratt served as vice president of the Academy during the past year, and also as Chairman of the Board of Directors. He is well-known to West Virginia physicians, having appeared as the banquet speaker at the 1959 annual meeting of the West Virginia Academy, AAGP, in Charleston.

Dr. James D. Murphy of Fort Worth, Texas, who has completed five terms as speaker of the Congress of Delegates, was elected vice president. Other new officers elected are as follows:

Dr. Albert E. Ritt, St. Paul, Minnesota, treasurer; Dr. Carroll Witten, Louisville, Kentucky, speaker; Dr. Lewis Cellio, Columbus, Ohio, vice speaker; and Drs. Donald Kast, Des Moines, Iowa, Walter Sackett, Jr., Miami, Florida, and Julius Michaelson, Foley, Alabama, members of the Board of Directors.

### West Virginia Physicians Attend Meeting

More than 50 West Virginia physicians attended the meeting. Total registration exceeded 7,000, including approximately 3,500 physicians.

Dr. Thomas H. Blake of St. Albans and Dr. Seigle W. Parks of Fairmont represented the Chapter at the meeting, and they attended all sessions of the Congress of Delegates. The alternates were Dr. Halvard Wanger of Shepherdstown and Dr. Logan W. Hovis of Parkersburg.

Looking ahead to the 200th anniversary of the birth of the nation in Philadelphia, the Academy announced that the 28th Annual Scientific Assembly will be held in that city in 1976.

## Curfew for Parents?

A teacher, doing research on her master's thesis on juvenile delinquency, telephoned a dozen homes at 9 P. M. to ask parents if they knew where their children were. Five of the calls were answered by children who had no idea where their parents were.—W. Va. School Journal.

## Dr. Julius L. Berkley Certified

Dr. Julius L. Berkley of Charleston has been certified by the American Board of Proctology.

## Travel Meeting of Ob. and Gyn. Society Held at Duke Medical Center

The Annual Travel Meeting of the West Virginia Obstetrical and Gynecological Society was held March 4-5, 1960 at the Department of Obstetrics and Gynecology of Duke University Medical Center in Durham, North Carolina. Dr. Bayard Carter was host.

An operative clinic was conducted by Doctor Carter and the members of his staff on Friday morning, March 4, at which time two cases were presented.

The following program was presented at the afternoon session:

"Osteoporosis"—Edwin G. Hamblen, M. D., Professor of Endocrinology and Associate Professor of Obstetrics and Gynecology.

"Intraepithelial Cancer"—Kenneth Cuyler, M. D., Head of the Cytology Department, Obstetrics and Gynecology.

"Endometriosis"—Robert N. Creadick, M. D., Associate Professor of Obstetrics and Gynecology.

Four papers were presented at the final session on Saturday morning, March 5, as follows:

"The Use of Hypotensive Drugs in Obstetrics"—Walter P. Cherney, M. D., Assistant Professor of Obstetrics and Gynecology.

"Salvage of Stillborns"—Doris Howell, M. D., Hematologist of the Pediatric Department.

"The Use of Artificial Kidney in Obstetrics and Gynecoloy"—R. T. Parker, M. D., Associate Professor of Obstetrics and Gynecology.

"Trichomoniasis and Mycotic Infections in Obstetrics and Gynecology"—Claudius P. Jones, Bacteriologist.

Doctor Carter was host at a dinner for the West Virginia physicians and their wives at the Hope Valley Country Club on the evening of March 4.

The following West Virginia physicians, accompanied by their wives, participated in the Travel Meeting:

Frederick H. Dobbs, R. R. Louft, U. G. McClure and Daniel Mairs of Charleston; Dwight P. Cruikshank, A. M. Dearman and Charles L. Goodhand of Parkersburg; Thomas H. Conaty, Edwin J. Humphrey and Gates J. Wayburn of Huntington; and A. J. Villani of Welch.

Dr. Odis Glover of Welch, and Dr. Eugene McClure of Charleston, also attended the meeting together with Dr. and Mrs. Art Cantwell of Shanwano, Wisconsin, who were present as guests of the group.

## Southern Medical Section Accepting Oph. and Otol. Papers

The Section on Ophthalmology and Otolaryngology of the Southern Medical Association has announced that papers by physicians located in the Association's area are now being accepted for consideration in connection with presentation at the Annual Meeting in St. Louis, October 31—November 3, 1960.

Papers or abstracts should be mailed as soon as possible to the secretary, Albert C. Esposito, M.D., 1212 1st Huntington National Bank Building, Huntington.

## Dr. Bernard Zimmermann Named Head Of WVU Department of Surgery

Dr. Bernard Zimmermann of St. Paul, Minnesota, has been appointed Professor and Head of the Department of Surgery at the West Virginia University School of Medicine. He will assume his duties at the Medical Center not later than July 1.

Doctor Zimmermann is now serving as a professor in the Department of Surgery at the University of Minnesota Medical School, where he has been a member of the staff since 1953. He is prominent in the field of cancer research and surgery and is the author of many surgical papers and monographs.

### Appointment Announced Late in March

The appointment of Doctor Zimmermann was announced late in March by the University Board of Governors, acting upon the recommendation of President Elvis J. Stahr, Jr., and Dr. Kenneth E. Penrod, vice president-medical affairs.

Bernard Zimmermann, M. D.

In a joint statement concerning the appointment, President Stahr and Doctor Penrod said "we feel very fortunate in getting a man for this position who is, by training and accomplishment, clearly one of the most outstanding young surgeons in the country. He already has attained remarkable stature in his field and gives promise of a brilliant future for surgery in West Virginia and its University Medical Center."

Dr. Owen H. Wangensteen, head of the Minnesota Department of Surgery, said Doctor Zimmermann's departure will constitute a serious loss for his institution, but added that the West Virginia University appointment is "as wise a choice as an institution seeking a good professor of surgery could possibly make.

"Doctor Zimmermann, I believe, is destined to become one of the great surgeons of this country. His competence is attested to by the circumstance that in this hospital, in which we have had a succession of aggressive cancer surgeons, Doctor Zimmermann's operative mortality in extended operations for cancer is perhaps as low as in the hands of the very best surgeons of the world."

### Graduate of Harvard Medical School

A native of St. Paul, Doctor Zimmermann received his secondary education at St. Paul Academy and was graduated from Harvard University in 1942. He received his M. D. degree from Harvard Medical School in 1945 and remained there three more years conducting research in the Department of Pharmacology. He served an internship at Boston City Hospital, 1945-46.

Doctor Zimmermann continued his postgraduate training at the University of Minnesota Medical School, where he received a Ph.D. degree in surgery in 1953. While pursuing his doctoral studies at Minnesota, he held a clinical fellowship from the American Cancer Society and a Damon Runyon Fellowship in cancer research.

### Staff Appointments at Minnesota

He was appointed an instructor in the Department of Surgery at the Minnesota Medical School in 1953; assistant professor, 1953; associate professor, 1956; and professor, 1959. During that time he also served as coordinator of the cancer training program.

Doctor Zimmermann was certified by the American Board of Surgery in 1953 and by the Board of Thoracic Surgery in 1957. He holds special appointments on the American College of Surgeons' Committee on Pre- and Postoperative Care, the United States Public Health Service Cancer Chemotherapy Study Section, and the Interim Committee of the Organization of Cancer Coordinators.

He is the son of the late Dr. Harry Bernard Zimmermann, former clinical professor of surgery at the University of Minnesota Medical School. He is married and the father of two children.

## Symposium for General Practitioners At Saranac Lake, July 11-15

The ninth annual Symposium for General Practitioners on Tuberculosis and Other Pulmonary Diseases will be held at Saranac Lake, New York, July 11-15. The symposium is sponsored by the American Trudeau Society, Saranac Lake Medical Society and Adirondack Counties Chapter of the New York State Academy of General Practice.

Sessions will be held in various sanatoria and laboratories in the Saranac Lake area. There will be elective sessions during afternoons of the five-day symposium and physicians will have the opportunity to make patient rounds.

The registration fee is $60 and a deposit of $10 should accompany the application. Further information may be obtained by writing Dr. John N. Hayes, General Chairman, Box 627, Saranac Lake, New York.

## Dr. Ray E. Burger Elected President Of W. Va. Chapter, ACS

More than 80 members and guests attended the annual meeting of the West Virginia Chapter of the American College of Surgeons which was held at The Greenbrier in White Sulphur Springs, April 1-2.

Dr. Ray E. Burger of Welch was installed as president for the coming year. He succeeds Dr. Kenneth G. MacDonald of Charleston.

Dr. Victor S. Skaff of Charleston was elected vice president, and Dr. Jack C. Morgan of Fairmont was named secretary-treasurer. Elected as councillors were Drs. John O. Rankin and Charles D. Hershey of Wheeling. and Kenneth G. MacDonald and William D. McClung of Charleston.

### Plaque Awarded to Doctor Moore

Dr. Thomas W. Moore of Huntington was awarded a plaque by the Chapter for "many years of outstanding service in surgery." He is the oldest member of the Chapter and one of the first members to join the organization.

The principal speakers were Dr. James D. Hardy, professor of surgery, University of Mississippi School of Medicine; Dr. George S. Phalen, assistant professor of orthopedic surgery, Frank E. Bunts Educational Institute, Cleveland Clinic, Cleveland, Ohio; and Dr. H. Glenn Bell, professor of surgery, University of California Hospital, San Francisco.

### Residents Awarded Prizes for Papers

In addition to the out-of-state speakers, a number of papers were presented by West Virginia physicians.

Prizes were awarded for the two best papers presented by residents. First prize was won by Dr. Tong Hyun Chang of Charleston who presented a paper on "Complicated Pelvic Fractures." Co-authors were Drs. George Miyakawa and Harold B. Sunday, also of Charleston.

Dr. Neopito L. Robles of Philippi won the second prize for a paper on "Carcinoma of the Cervix." Dr. Karl J. Myers of Philippi was the co-author.

### Plans Discussed for WVU Medical Center

One of the highlights of the meeting was a discussion of the plans for the clinical operation of the West Virginia University Medical Center at Morgantown.

University President Elvis J. Stahr, Jr., spoke briefly and introduced Dr. Kenneth E. Penrod, vice president—medical affairs, who presented a paper on "Projected Clinical Operation of the West Virginia University Medical Center."

President Stahr also introduced Dr. Bernard Zimmermann of St. Paul, Minnesota, who was appointed recently as professor of surgery at the West Virginia University School of Medicine. He will assume his duties not later than July 1.

## Need for Local Committees on Aging

We know that the widespread interest and concern for older people can sometimes, unfortunately, result in misguided and undesirable programs. The organization of effective committees in every local medical society and the systematic involvement of individual physicians in community activities dealing with aging can assure sound programs and maintain our high standards of private medical care. It is one of the most important steps the medical profession can take—and one of the most urgently needed.—Ralph Perry, M. D., in Missouri Medicine.

**Out-of-state speakers at the annual meeting of the West Virginia Chapter, ACS, at The Greenbrier were (left photo), left to right, Dr. H. Glenn Bell of San Francisco, Dr. James D. Hardy of Jackson, Mississippi, and Dr. George S. Phalen of Cleveland, Ohio.**

**New officers of the West Virginia Chapter, American College of Surgeons, are shown in the other photo following their election at the annual meeting of the Chapter at The Greenbrier early in April. Left to right (seated), Dr. Jack C. Morgan, Fairmont, secretary-treasurer; Dr. Ray E. Burger, Welch, president; and Dr. Victor S. Skaff, Charleston, vice president. Standing, Dr. John O. Rankin, Wheeling, councillor; Dr. Kenneth G. MacDonald, Charleston, retiring president and councillor; and Dr. William D. McClung, Charleston, councillor. Another councillor, Dr. Charles D. Hershey of Wheeling, was absent when the picture was taken.**

## West Virginia Well Represented At Conference on Aging

More than 600 persons attended a Regional Conference on Aging which was held at the Southern Hotel in Baltimore, Maryland, March 30-31. The conference was sponsored by the American Medical Association and the medical associations of West Virginia, Virginia, Maryland, Delaware, New Jersey and the District of Columbia.

Various organizations in West Virginia were represented at the meeting and it was estimated that 75 persons attended from the state.

Dr. E. Lyle Gage of Bluefield, a past president of the West Virginia State Medical Association and chairman of the Committee on Aging, presented an address before the first general session on Wednesday morning, March 30. His subject was "Meeting the Challenge to Society."

(Doctor Gage's paper which he presented at Baltimore appears in the scientific section of this issue of *The Journal*).

Another speaker at that session was Mrs. John F. McCuskey of Clarksburg, a past president of the State Auxiliary and currently president of the West Virginia Federation of Women's Clubs.

Dr. George F. Evans, immediate past president of the State Medical Association and chairman of the Council, served as presiding officer at the final general session on Thursday morning, March 31.

Doctors Gage and Evans also participated in a panel discussion at the conclusion of the formal speaking program on Thursday morning.

The Woman's Auxiliary to the West Virginia State Medical Association was represented by Mrs. Robert R. Pittman of Marlinton, the president; Mrs. Clark K. Sleeth of Morgantown, president elect; and Mrs. G. Thomas Evans of Fairmont, immediate past president. Mrs. Charles L. Goodhand of Parkersburg, first vice president of the AMA Auxiliary, also attended the meeting.

**Dr. E. Lyle Gage of Bluefield was among the principal speakers at the AMA Regional Conference on Aging in Baltimore. The subject of his paper, which is printed elsewhere in this issue, was "Meeting the Challenge to Society."**

One of the highlights of the meeting was an address by Dr. Louis M. Orr of Orlando, Florida, president of the American Medical Association, who was the guest speaker at a luncheon meeting on March 30.

Other guest speakers included Dr. David B. Allman of Atlantic City, New Jersey, and Dr. Edward L. Bortz, both past presidents of the AMA, and Dr. Theodore G. Klumpp of New York City, who appeared as a guest speaker at the annual meeting of the West Virginia State Medical Association in 1959.

Dr. Frederick C. Swartz of Lansing, Michigan, chairman of the AMA Committee on Aging, presided at the conference. Other regional meetings were held in San Francisco, New Orleans and Atlanta.

**Among the West Virginians attending the AMA Regional Conference on Aging in Baltimore were (left photo), left to right, Dr. N. Allen Dyer of Bluefield, Dr. B. S. Brake of Clarksburg and Dr. Deane F. Brooke of Beckley.**

**In the other photo, left to right, Dr. E. Lyle Gage of Bluefield, Mrs. John W. Hash of Charleston, who represented the Governor's Commission on Aging, Dr. George F. Evans of Clarksburg, Mrs. C. A. Jackson of Wheeling, who represented the Episcopal Diocese of West Virginia, and Dr. John W. Hash of Charleston.**

## Large Attendance Expected at Annual AMA Meeting in Miami Beach

More than 15,000 physicians are expected to attend the 109th annual meeting of the American Medical Association in Miami Beach, Florida, June 13-17. Several thousand members of the Woman's Auxiliary are also expected to be in attendance for that organization's annual meeting which will be held during the same week.

General headquarters for the meeting will be at the Americana Hotel, where the AMA House of Delegates will meet throughout the week. The scientific sessions, films, color TV and the scientific and industrial

E. Vincent Askey, M. D.

Louis M. Orr, M. D.

exhibits will be in the Miami Beach Exhibition Hall and several ocean-front hotels.

Presiding at the meeting will be Dr. Louis M. Orr of Orlando, Florida, AMA President. He will deliver addresses before the House of Delegates and Auxiliary, and will participate in inaugural ceremonies for Dr. E. Vincent Askey of Los Angeles, California, who will succeed him as president.

### State Delegates to Attend Meeting

The West Virginia State Medical Association will be represented at meetings of the House of Delegates by Dr. Frank J. Holroyd of Princeton and Dr. Charles A. Hoffman of Huntington. The alternate delegates are Dr. Thomas G. Reed of Charleston and Dr. J. C. Huffman of Buckhannon.

### Scientific Program

Approximately 2,000 physicians will participate in presenting the scientific program. The first general scientific session on Monday afternoon, June 13, will feature the Joseph Goldberger Lecture on Clinical Nutrition. The lecture will be followed by a symposium on nutrition.

The second session on Tuesday morning will be a symposium on "Evaluation and Preparation of Patients for Anesthesia and Surgery." The sections on Anesthesiology, Diseases of the Chest, General Practice, Internal Medicine, Pediatrics, Pathology and Physiology, and Surgery are sponsors of this portion of the program.

Nearly 300 scientific exhibits will be on display in the Exhibition Hall. A new exhibit on "Body Fluid Disturbances," offering a complete course in body fluids, will be presented in its entirety on two days.

Another exhibit on fractures will include booths on fractures of the ankle, hip, wrist, tibia and fibula, children's fractures, and fractures resulting from falls on the outstretched hand. Fifty orthopedic surgeons will participate in the demonstrations at this exhibit.

### AMA Golf Tournament

The annual medical golf tournament will be held in connection with the convention at the Diplomat Hotel and Country Club, Hollywood-By-The-Sea, Florida, on Monday, June 13. The sponsor of the tournament is the American Medical Golf Association. There will be a banquet and prizes for all participating physicians.

Information concerning the tournament may be obtained by writing to the American Medical Golf Association, 1324 Professional Building, Kansas City, Missouri.

### Pre- and Post-Convention Tours

Several pre- and post-convention tours have been arranged for physicians and their families who plan to attend the meeting in Miami Beach. The World Travel Plan Corporation, 150 East 50th Street, New York 22, New York, offers week-long trips to Nassau prior to and following the convention.

Another agency, Universal Tours of Miami, has arranged similar Caribbean tours to Nassau and Jamaica. Inquiries should be addressed to M. John Hanni, Jr., Executive Secretary, Dade County Medical Association, 2 Southeast 13th Street, Miami 32, Florida.

Further information concerning prices, transportation and lodging may be obtained by contacting the above agencies.

## Foreign Fellowship Program For Medical Students

A fellowship program designed to further medical education by sending future physicians to remote areas of the world was announced recently by the Association of American Medical Colleges.

Dr. Ward Darley, executive director of the AAMC, said the program would "enable selected medical students to gain wide clinical experience as well as assist in the continuing war against disease in the backward areas of the world."

The three-year program, established under a $180,000 grant from Smith Kline and French Laboratories, is open to all medical students who have completed their third year of study. Scheduled to begin this summer, the program will permit an average of 30 students to participate each year.

Eligible students who are prepared to spend an average of 12 weeks working in foreign locales are urged to submit applications to their respective deans for review. Following initial screening, up to three applications for each school will be forwarded to a panel of physicians who will make up the selection committee.

## AMA Woman's Auxiliary To Meet In Miami Beach, June 13-16

The 37th annual meeting of the Woman's Auxiliary to the American Medical Association will be held in Miami Beach, Florida, June 13-16. General headquarters for the convention will be at the Hotel Deauville.

The Auxiliary has extended to wives of West Virginia physicians planning to attend the convention a cordial invitation to participate in all social functions and general meetings of the Auxiliary.

The formal opening of the meeting will be at 9:30 A. M. on Monday, June 13, with the president, Mrs. Frank Gastineau of Indianapolis, Indiana, presiding.

### Mrs. Goodhand on Program

Mrs. Charles L. Goodhand of Parkersburg, first vice president of the AMA Auxiliary, will be among the speakers at the first session on Monday. She will also serve as moderator for several panel discussions on membership that will be presented before three groups, based on membership in each state.

Mrs. Goodhand is a past president of the Woman's Auxiliary to the West Virginia State Medical Association, and served several terms as chairman of the Legislative Committee of the AMA Auxiliary. She is currently serving as chairman of the Membership Committee, in addition to her duties as first vice president.

### Installation of New President

A luncheon in honor of the past presidents of the Woman's Auxiliary will be held at noon on Tuesday. The guest speaker will be Dr. Louis M. Orr of Orlando, Florida, president of the American Medical Association.

Election of new officers will be held on Wednesday morning, and Mrs. William Mackersie of Detroit, Michigan, who will be installed as president, will present her inaugural address.

A post-convention planning meeting for national officers, directors, committee chairmen, state presidents and presidents-elect will be held on Thursday afternoon, June 16. The guest speaker will be Dr. Ernest B. Howard of Chicago, assistant executive vice president of the AMA.

### Entertainment Program for Children

Mrs. Richard F. Stover, convention chairman, announced that an entertainment program has been arranged for elementary and teen-age children who accompany their parents to Miami Beach.

The program will include tours of Miami Beach and surrounding areas, cabana parties, sightseeing cruises and ice skating on the artificial rink at the Deauville Hotel.

## Memory Going?

There is a wicked inclination in most people to suppose an old man decayed in his intellects. If a young or middleaged man when leaving the company does not recollect where he laid his hat, it is nothing; but if the same inattention is discovered in an old man, people will shrug up their shoulders and say, "His memory is going."—Samuel Johnson.

## Dr. John F. Morris To Attend Meeting On Prepaid Health Insurance

Dr. John F. Morris of Huntington will represent the West Virginia State Medical Association at the "National Congress on Prepaid Health Insurance" which will be held at the Drake Hotel in Chicago, May 13-14.

The program for the two-day meeting, which will be sponsored by the American Medical Association's Council on Medical Service, will be concerned primarily with the present status and problems of voluntary health insurance in the United States.

Dr. J. Lafe Ludwig of Los Angeles, California, chairman of the Council on Medical Service, will preside at the meeting. Dr. Louis M. Orr of Orlando, Florida, president of the AMA, will be among the guest speakers.

## Medical Meetings, 1960

The following is a partial list of national, state and district medical meetings scheduled for 1960:

May 6-8—W. Va. Chap. AAGP, Charleston.
May 12-13—W. Va. PH Assn., Bluefield.
May 21-22—W. Va. Assn. Medical Assistants, Blackwater Falls Lodge.
May 26—Tri-County Medical Meeting, Morgantown.
June 13-17—AMA Annual Meeting, Miami Beach, Fla.
July 11-13—Medical Licensing Board, Charleston.
**Aug. 25-27—93rd Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.**
Sept. 13-15—National Cancer Conf., Minneapolis.
Sept. 22-24—W. Va. Hospital Assn., White Sul. Springs.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 10-14—ACS, San Francisco.
Oct. 21-25—Am. Heart Assn., St. Louis.
Oct. 21-23—PG Institute, Martinsburg.
Oct. 31-Nov. 3—Southern Medical, St. Louis.
Nov. 29-Dec. 2—AMA Clinical Meeting, Washington, D. C.

## Dr. L. C. Smith New Health Officer For Wayne County

Dr. Larry C. Smith of Ceredo has been appointed health officer for Wayne County, succeeding Dr. Michael M. Stump who resigned to accept a residency in pathology at Texas Medical Center, Baylor University, in Houston, Texas. Doctor Smith assumed his new duties on March 11, 1960.

## PG Course in Arthritis

A Postgraduate Seminar in Arthritis and Related Diseases will be held at the Diplomat Hotel in Hollywood, Florida, June 11-12, immediately preceding the annual meeting of the American Medical Association in Miami Beach.

Registration fee for the course is $15, and physicians will be given 8 hours category I credit for attendance by the American Academy of General Practice. Further information concerning the meeting may be obtained by writing Ralph E. Nollner, Executive Director, The Arthritis and Rheumatism Foundation (Florida Chapter), 1206 Huntington Medical Building, Miami 32, Florida.

## Dr. J. A. B. Holt Installed as President Of W. Va. Acad., Oph. & Otol.

Dr. John A. B. Holt of Charleston was elevated to the presidency of the West Virginia Academy of Ophthalmology and Otolaryngology during the 13th annual meeting of that organization at The Greenbrier in White Sulphur Springs, April 10-12.

Doctor Holt, who has been serving as president elect during the past year succeeds Dr. Nime K. Joseph of Wheeling, the retiring president. Other new officers elected are as follows:

Dr. Albert C. Esposito, Huntington, president elect; Dr. William K. Marple, Huntington, vice president; Dr. Worthy W. McKinney, Beckley, secretary-treasurer; and Dr. R. Alan Fawcett, Wheeling, director (two-year term).

Total registration at the three-day meeting was 54 and this included physicians from Ohio, Indiana, Pennsylvania, New York, Connecticut, New Jersey, Maryland, Delaware, Virginia, Illinois, Rhode Island and Washington, D. C.

Five prominent physicians appeared as guest speakers before the general scientific sessions. Each speaker presented two papers during the meeting.

One of the speakers was Dr. Harold G. Scheie of Philadelphia, professor of ophthalmology at the University of Pennsylvania School of Medicine, and chairman of the Section of Ophthalmology of the American Medical Association.

Dr. Albert C. Esposito of Huntington served as chairman of the scientific committee which arranged the program. Other members were Drs. Edwin M. Shepherd of Charleston, Worthy W. McKinney of Beckley, Ralph W. Ryan of Morgantown, and Lyle B. McGinnis of Huntington.

Guest speakers at the annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology were, left to right (seated), Dr. Helen J. Ossofsky of Washington, D. C., and Dr. Charles E. Iliff of Baltimore. Standing, Dr. Harold G. Scheie of Philadelphia, Dr. Oscar J. Becker of Chicago, and Dr. John T. Dickinson of Pittsburgh.

Doctor Joseph presided at the business meeting held on Tuesday, April 12, and he announced the appointment of a special committee on Hearing Conservation and Rehabilitation.

Dr. James T. Spencer of Charleston was named chairman of the committee and the other members are Drs. Albert J. Paine of Bluefield, Sobisca S. Hall of Clarksburg, William K. Marple of Huntington and John A. B. Holt of Charleston.

Doctor Spencer said the committee will evaluate the present status of programs in the state that are concerned with problems of the hard of hearing, and will survey the work of case finding in the public schools.

Officers of the West Virginia Academy of Ophthalmology and Otolaryngology are shown during the annual meeting of the Academy at The Greenbrier, April 10-12. Left to right, Dr. Albert C. Esposito, Huntington, president elect; Dr. John A. B. Holt, Charleston, president; Dr. William F. Beckner, Huntington, retiring director; Dr. Nime K. Joseph, Wheeling, retiring president; Dr. William K. Marple, Huntington, vice president; and Dr. James T. Spencer, Charleston, director. Absent when the picture was taken were Dr. Worthy W. McKinney of Beckley, secretary-treasurer, and Dr. R. Alan Fawcett of Wheeling, director.

# Poison Control Centers

# In Operation 24 Hours a Day

## CENTERS IN OPERATION

**Beckley**
Beckley Hospital
1007 S. Oakwood Ave.
CL 2-6431

**Belle**
DuPont Belle Works
WI 9-4313
(Information Only)

**Charleston**
Memorial Hospital
3200 Noyes Ave., S. E.
DI 4-1741

**Clarksburg**
St. Mary's Hospital
464 Washington St.
MA 4-7611

**Huntington**
Cabell-Huntington Hospital
1340 16th Street
JA 5-0301

St. Mary's Hospital
2900 1st Avenue
JA 3-7466

**Parkersburg**
Camden-Clark Hospital
717 Ann Street
HU 5-5531

St. Joseph's Hospital
1801 Market Street
HU 5-5421

**Pine Grove**
The Pine Drug Store
TU 9-8500
(Information Only)

**Ronceverte**
Greenbrier Valley Hospital
MI 7-4411

**Weston**
Stonewall Jackson Mem. Hosp.
502 Main Avenue
Phone: 1775

The West Virginia Medical Journal

June, 1960 Vol. 56, No. 6

# Blastomycosis*

*Harry E. Walkup, M. D.*

North American blastomycosis, or Gilchrist's disease, is a chronic infection caused by a specific fungus, Blastomyces dermatitidis. Although this organism was first described by Thomas C. Gilchrist in 1894, the basic concepts of this disease, as we know them today, were not established until a group of investigators in Chicago revived it as a clinical entity in the early 1920's—hence its colloquial name "Chicago Disease"—and later Martin and Smith of Duke University published a series of articles on blastomycosis beginning in 1935. Actually, credit is due Martin and Smith for establishing a definite geographic distribution of the disease, demonstrating it to be a disease of young adults with no racial predilection, and establishing its tendency to infect persons of the poor classes with occupations that expose them to nature's elements. They assumed the infection to have an exogenous source, gaining entry through the upper respiratory passages or the skin, and demonstrated its lack of contagiousness insofar as man-to-man transmittal is concerned.

### Portal of Entry of B. Dermatitidis

Two distinct schools of thought exist as to the portal of entry of B. dermatitidis. David T. Smith of Durham, North Carolina, is of the opinion that blastomycosis exists in two distinct forms: the cutaneous and the systemic. This worker feels that there is a cutaneous form that arises from a primary pulmonary focus and metastasizes via the blood stream to create a secondary cutaneous implantation. He also feels, however, that a primary form of cutaneous blastomycosis exists in the absence of primary pulmonary disease. Schwartz and Baum, on the other hand, feel that both the pulmonary and cutaneous forms represent variable reactions of the host and that the portal of entry is most likely through the upper respiratory passages in all instances. The extent of the pulmonary lesion depends on the immunity and hypersensitivity of the host, and in many instances secondary involvement of the skin, genito-urinary system, bones and other organs can occur without a roentgenographically demonstrable pulmonary focus.

***The Author.***

- **Harry E. Walkup, M. D., Chief, Surgical Services, Veterans Administration Hospital, Oteen, North Carolina.**

### Growth of the Organism

The organism, B. dermatitidis, grows as a mold (mycelial form) on artificial media (Sabouraud's glucose agar slants) at room temperature (20° C.). At body temperature (37° C.), the organisms are cultured on blood agar or beef infusion glucose agar with the production of yeast-like budding organisms. In tissue sections, the organism appears as a double refractile yeast form with an oval or round body 5 to 20 micra in diameter, containing granular contents and single buds. The identification of these organisms in tissue sections has been facilitated in recent years by the use of the periodic Acid-Schiff and the Gomori silver methenamine staining techniques. Animal inoculations can be performed using mice or guinea pigs, but these are used only as adjuncts to diagnosis since the inoculation of pathogenic fungi into animals often does not produce lesions. This fact is especially true for many strains of blastomyces.

When the organism, B. dermatitidis, gains entry into the lung, the characteristic reaction

*Presented before the annual meeting of the Potomac Chapter of the American College of Chest Physicians, at The Greenbrier in White Sulphur Springs, October 9, 1959.
Submitted to the Publication Committee, November 5, 1959.

consists of an initial outpouring of polymorphonuclear leucocytes. Soon thereafter these cells are accompanied by lymphocytes which occur in focal aggregates. Later other cells characteristic of long-standing infection appear, namely, plasma cells, mast cells, histiocytes, and Langhan's giant cells. The response resembles the reaction of the lung to M. tuberculosis but is characterized by a more protracted suppurative stage with microabscesses replacing the characteristic caseation of tuberculosis. The formation of tubercles is not as pronounced in blastomycosis as it is in tuberculosis. Pulmonary involvement will vary from an exudative type of pneumonia with early granuloma formation to a lesion that is primarily granulomatous consisting of epithelioid cells and giant cells. Cavitation does occur in blastomycosis and is almost indistinguishable roentgenographically from tuberculosis and lung abscess.

### Immunological Reactions

Immunological reactions vary from case to case, depending on the number and pathogenicity of organisms and the allergy and immunity of the host. In general, the rapid fulminating systemic infections usually exhibit a marked degree of hypersensitivity with negative or low complement fixing antibody titers, whereas the more chronic, slowly progressing infections demonstrate little or no sensitivity, with complement fixing titers in the higher dilutions. In evaluating complement fixation tests and skin tests, one should be aware of the possibility of cross reactions from the antigens of the other common fungus diseases, histoplasmosis and coccidioidomycosis. Errors in this regard usually can be obviated if tests for these three diseases are performed simultaneously. The offending disease will produce the strongest cutaneous response. Charlotte Campbell of Walter Reed Medical Center, however, recently has demonstrated that cross titers can occur which result in a higher complement fixing antibody titer reaction to one of the other fungus antigens than that produced by the direct causative disease.

The cutaneous lesions of blastomycosis begin as a papule or papulopustule of the superficial skin layer. The lesions spread slowly by peripheral extension, the contour of the lesion often assuming a serpiginous shape. The central parts of the lesion undergo spontaneous healing, forming scars which show only a slight tendency to contracture.

### Symptoms

The symptoms of pulmonary blastomycosis consist of fever, malaise, weight loss, chest pain, cough, dyspnea and, in many instances, hemoptysis. Diagnosis is established by demonstration of the organism from the sputum or endobronchial smear. Corroborative diagnostic evidence is obtained through skin tests and complement fixation tests.

Roentgenographic signs are not distinctive and may present as miliary nodulations, ill-defined tuberculous-like lesions, pulmonary consolidations with or without cavitation, well defined solitary lesions or, rarely, as a thin-walled cyst. The consolidations often appear at the hilum and this finding plus hemoptysis frequently leads to a mistaken diagnosis of bronchiogenic carcinoma. Pleural effusion is not an outstanding finding, although fibrous thickening of the pleura is not an unusual finding at operation or autopsy. It might be emphasized that pulmonary effusion is so rare a complication of blastomycosis that careful search should be made for the presence of tuberculosis when it is present even in the face of an active pulmonary blastomycosis lesion.

As stated previously, any organ in the body may become involved in the course of a systemic infection but the common sites are the skin, lower genito-urinary system, bones and central nervous system. I would like to call particular attention to the involvement of the prostate gland. In isolated prostatic involvement the urine may or may not yield a positive culture, whereas the prostatic secretions will invariably give positive bacteriological findings. We routinely examine the prostatic secretions in all cases of proven or suspected pulmonary blastomycosis and are occasionally rewarded with the additional diagnosis of prostatic involvement. The importance of making this diagnosis rests with the fact that prostatic blastomycosis is more refractory to specific therapy and its presence may warrant more extensive treatment and follow-up.

### Treatment

As to treatment, it is interesting that Martin and Smith, in 1939, demonstrated that in 93 per cent of cases diagnosed as systemic blastomycosis the patients were dead within three years from the date of onset. These authors advocated the use of potassium iodide in the treatment of this disease, and advised preliminary desensitization with a vaccine made from the blastomyces in those cases exhibiting a positive skin test. This therapeutic regimen enjoyed a measure of success but it was not until the discovery of the specific action of the diamidines, in 1950, Propimidine, Stilbamidine and 2-hydroxystilbamidine, that real progress was made in the treatment of blastomycosis. These preparations, although not curative in all instances, will enable the patient either to heal the acute lesions or to survive the acute phase of the disease, with subsequent re-

duction of the process to a chronic form. If lung destruction is present or if a chronic granuloma persists, these preparations will enable the patient to have pulmonary excisional procedures performed without the danger of dissemination. Another drug that has been used successfully at our institution is undecylenic acid. This drug was introduced by Murphy and Hopkins, in 1952, and showed promise during the period when stilbamidine, with its annoying side-effect of trigeminal neuralgia, was being used. Undecylenic acid inhibits B. dermatitidis *in vitro* but does not measure up to 2-hydroxystilbamidine in its therapeutic efficacy. Two-hydroxystilbamidine became available soon after our discovery of undecylenic acid for the treatment of this disease and this new and more widely accepted drug overshadowed this agent. We prefer 2-hydroxystilbamidine and use undecylenic acid as a second choice drug, or in combination with the former drug in recalcitrant cases. The latest drug to be employed in the treatment of blastomycosis is Amphotericin-B, a product of E. R. Squibb & Company. This is an antibiotic formed from a species of Streptomyces which was isolated from a soil sample obtained on the *Orinoco* river in South America. Although it is too early to truly evaluate this drug, it shows promise in the treatment of blastomycosis, cryptococcosis, histoplasmosis, coccidioidomycosis and monilial infections. Dr. David Smith has made the statement that this preparation may prove to be a broad spectrum antifungus agent. Early reports are encouraging and we eagerly await further evaluation of this preparation in the treatment of North American blastomycosis.

### Summary

Our blastomycosis series consists of twenty patients, seven of whom had diseased lung resected. Of the seven surgical patients, two died. One succumbed to disseminated blastomycosis six months after surgery, while the second (who also had bronchiogenic carcinoma and pulmonary tuberculosis as well as pulmonary blastomycosis) died of pulmonary insufficiency. The five patients who survived pulmonary resection are well clinically, but two have residual lesions and blastomyces dermatitidis in the sputum, in spite of intensive therapy with the aromatic diamidines. One of these patients has been given also Amphotericin-B recently. Following this therapy his sputum converted to negative but insufficient time has elapsed to evaluate truly the result of treatment.

Of the thirteen patients who did not have resective lung surgery, three died: two with disseminated blastomycosis, and one (on whom no autopsy was performed) with proven cutaneous blastomycosis with pulmonary cavitation. This patient had a sputum positive for AFB and negative for B. dermatitidis. His death was attributed to pulmonary tuberculosis by his attending physician. Ten patients are living who did not have pulmonary resection. At the time of this presentation all ten are apparently cured of their blastomycosis disease (6 pulmonary, 2 prostatic and pulmonary, 1 cutaneous, and one cutaneous and laryngeal lesion). One, a cutaneous case, refused treatment and left the hospital. This patient is well at present. One patient who had prostatic involvement developed dissemination when the prostatic abscess was incised, in 1951. He was treated with both stilbamidine and 2-hydroxystilbamidine which resulted in a cure of his generalized dissemination, but prostatic secretions remained positive for B. dermatitidis for a period of seven years. At the end of that time he was admitted to the hospital in Addisonian crisis. He was treated with steroids and 2-hydroxystilbamidine therapy. Subsequent to this treatment the patient responded to steroid therapy and is on a maintenance dose of this drug at the time of this writing. Several prostatic smears performed during the past year have demonstrated no evidence of active blastomycosis.

Stilbamidine or 2-hydroxystilbamidine, or both, had been used in nine patients of the entire group of twenty; undecylenic acid in twelve; Amphotericin-B in three. Seven patients had more than one of these four drugs, and one patient received all four.

A review of the literature revealed 113 cases in which the patient had been treated with the diamidines, 12 of which also underwent surgery. Table I divides these cases into those receiving stilbamidine and 2-hydroxystilbamidine therapy. Mortality figures and results are tabulated. Table II deals with 40 of the original 113 patients who were followed for one year or longer after their diamidine therapy. The high recurrence rate is impressive. Table III lists the pulmonary resections for blastomycosis that have been reported in the literature. Some of these patients received diamidines with their surgery and others did not. None of the cases that disseminated and died in the postoperative period had received one of the diamidines. (See Tables I, II, and III, next page.)

### Conclusions

1. Present day treatment of North American blastomycosis leaves much to be desired.

2. Aromatic diamidines are useful drugs but a distressingly high proportion of patients suffer a relapse following therapy.

3. Surgery, without drug coverage, can be dangerous, as evidenced by an appreciable number of patients exhibiting dissemination of the disease in the postoperative period.

4. Amphotericin-B may prove to be a more effective drug than the diamidines but at this time we have insufficient data for adequate appraisal of its effectiveness.

**Table I**

**RESULTS OF TREATMENT WITH THE AROMATIC DIAMIDINES**

| *Drug* | *No.* | *Mortality** | *RESULTS* *Good* | *Poor* |
|---|---|---|---|---|
| Stilbamidine | 75** | 6 (8%) | 76% | 24% |
| 2-OH Stilbamidine | 38 | 1 (3%) | 73% | 27% |

*Diamidines administered late in course of disease in many instances.

**56% of the patients receiving Stilbamidine developed trigeminal neuralgia.

**Table II**

**RESULTS OF DIAMIDINE TREATED PATIENTS FOLLOWED ONE YEAR OR LONGER**

| *No.** | *Recurrence of Blastomycosis* |
|---|---|
| 40 | 13 (33%) |

*40 of original 113 cases followed 1 Yr. or longer.

**Table III**

**RESULTS OF EXCISIONAL SURGERY FOR PULMONARY BLASTOMYCOSIS**

| | *MORTALITY* | | *RESULTS* | |
|---|---|---|---|---|
| *No.* | *Dissemination of Blastomycosis* | *Unrelated Causes* | *Good* | *Poor* |
| 47 | 6* (13%) | 5 (11%) | 27 (57%) | 9 (19%) |

*None of these patients received Diamidine therapy.

# Growing Old Gracefully

We are the summation of our past. In providing, therefore, that the aging process can be satisfactory as present knowledge would allow, the field has to be surveyed in its emotional, socio-economic, and medical aspects. These three react on each other.

The emotional phase of the situation can be served only if the individual's sense of importance and of his being useful are maintained, and he must be employed in a manner satisfactory to himself.

The socio-economic phase is life's central problem for most individuals living in a highly organized society. This, equally with the emotional phase, is intimately bound up with the individual's educational and social opportunities, extending over a lifetime.

The medical aspect of this whole situation can be presented more closely to our view, and is susceptible of care and adjustment within our limits of knowledge. It cannot be expected to correct deficiencies in the first two. However, it is said that medical science has provided these added years to the life of our senior citizens and now must provide them with the means of living those years satisfactorily. Such an assumption presumes on an amount of medical knowledge not presently at hand. It also presumes by such means to correct deficiencies in related fields.

Medical science has achieved at least partial success in sanitation and hygiene, somewhat less success and control in infections, but its ability at present to delay or minimize the effects of the degenerative diseases is negligible.

The attempts to improve the status of those who are aging, by decree, would be as ineffective as it may be ludicrous. Examples of this are enforced retirement, the Forand bill, and the various attempts to do for the aged what they would much prefer to do for themselves.

Aging, therefore, is a community responsibility. Preparations for its proper management must begin in early life and must include adequate attention by the individual in all three spheres of his life's pattern. Only in such a manner can he grow old gracefully.—Journal, Louisiana State Medical Society.

# Treatment of Herpes Zoster Ophthalmicus

## (With Case Reports)

*Edward Shupala, M. D.*

Ophthalmic herpes zoster is characterized by vesicular lesions distributed along the course of the ophthalmic branch of the fifth cranial nerve. There usually is considerable edema of the face in the early stages. Ophthalmic zoster usually is painful and often the pain is distressingly intense. The pain may occur before, during and after the eruption. Intractable postherpetic neuralgia may develop, particularly in elderly patients.

Ocular complications are common: ophthalmic lesions, pain in the eyes, insensitive cornea, secondary glaucoma, lowered visual acuity, recurrent low grade uveitis, and others.

The cases of herpes zoster ophthalmicus with ocular complications are of particular interest to the ophthalmologist. Many severely painful cases without ocular complications are seen in general practice.

Local symptomatic treatment often is helpful in permitting regrowth of the destroyed epithelium. The antibiotics are useful only in the treatment of any secondary infection and have no effect on the viral infection. The remedies used in the treatment of herpes zoster ("shingles") have been employed also in ophthalmic cases, with similar therapeutic limitations.

Weintraub,[1] also Rodarte and Williams,[2] reported favorably on the use of gamma globulin in the treatment of herpes zoster. Epstein and Allington,[3] however, reported that gamma globulin was worthless in such cases. MacLatchy[4] reported favorably on the treatment of three patients with cyanocobalamine (vitamin $B_{12}$). The number of patients treated was too small to permit any valid conclusions. Carter and Royds,[5] for investigative purposes, used prednisone in fifteen cases. They observed no effect on the incidence of ophthalmic complications or postherpetic neuralgia. They did not draw any conclusions regarding the efficacy of this therapy, though some symptomatic benefits were observed. Also, these investigators pointed out the dangers of steroid therapy in the treatment of viral diseases. Fatalities occurring in chickenpox have been associated with steroid therapy.[6]

Submitted to the Publication Committee, December 8, 1959.

*The Author*

- Edward Shupala, M. D., 1052 Market Street, Parkersburg, W. Va.

Sforzolini[7] recently reported his results in 42 cases of ophthalmic herpes zoster treated with a preparation containing denatured proteolytic enzyme (Protamide®). A favorable response was obtained in all cases. In particular, pain was alleviated, subsiding after the first few injections of Protamide. No postherpetic neuralgia was observed, and local or systemic reactions were entirely absent. Field[8] reported excellent response in one case treated with Protamide.

### Case Reports

This report presents brief case histories of three patients with ophthalmic herpes zoster treated with Protamide. The herpetic infection was severe in all three cases, and involved the first branch of the fifth cranial nerve. In one case, the second branch also was involved The cornea was not affected in any of the cases.

The table summarizes case data.

Treatment consisted solely of the intramuscular injection of one ampul (1.3 cc.) of Protamide daily for four days, except in one secondarily infected case in which therapy was continued for one additional day and an antibiotic employed for the bacterial infection.

All three patients began to show definite improvement within 24 hours after receiving Protamide. After completion of treatment, marked clearing of the lesions was observed in all cases. Postherpetic neuralgia did not develop in any case.

In two cases (females), symptoms were present for three days before Protamide therapy was instituted and for over a week in one case (male). In the latter case, secondary infection developed, requiring antibiotic therapy in addition to Protamide therapy. Paresthesia occurred prior to the skin lesions in all these cases. Fig-

®Sherman Laboratories.

ures 1 and 2 are representative of the severity of the herpetic infection before Protamide was instituted.

### Summary

The results obtained in three severe cases of herpes zoster ophthalmicus treated with Protamide are reported. They confirm the reports of Sforzolini and Field with this therapy in a combined total of 43 cases.

Protamide provided more satisfactory results in our hands than any other previously employed

**TABLE: OPHTHALMIC HERPES ZOSTER CASES TREATED WITH PROTAMIDE**

| *Patient* | *Age* | *Sex* | *Duration of Eruptions Prior To Therapy* | *Nerve Involvement* | *Corneal Involvement* | *Pain* | *Duration of Protamide Therapy** | *Therapeutic Effects* | *Concurrent Therapy* |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 45 | M | 7 days | V-1 | no | Severe pain with subsequent eruptions in involved areas. | 5 days | Improvement within 24 hours. Excellent relief of pain. Improvement of vesicles and sensory in 6 days. | Antibiotics for secondary infection. |
| 2 | 75 | F | 3 days | V-1 V-2 | no | " | 4 days | Relief of pain; improvement of vesicles; some sensory improvement. Paraesthesia not completely cured. | none |
| 3 | 55 | F | 3 days | V-1 | no | " | 4 days | Improvement within 24 hours. Complete relief and sensory improvement in 5 days. | none |

*Daily intramuscular injections of 1.3 cc.

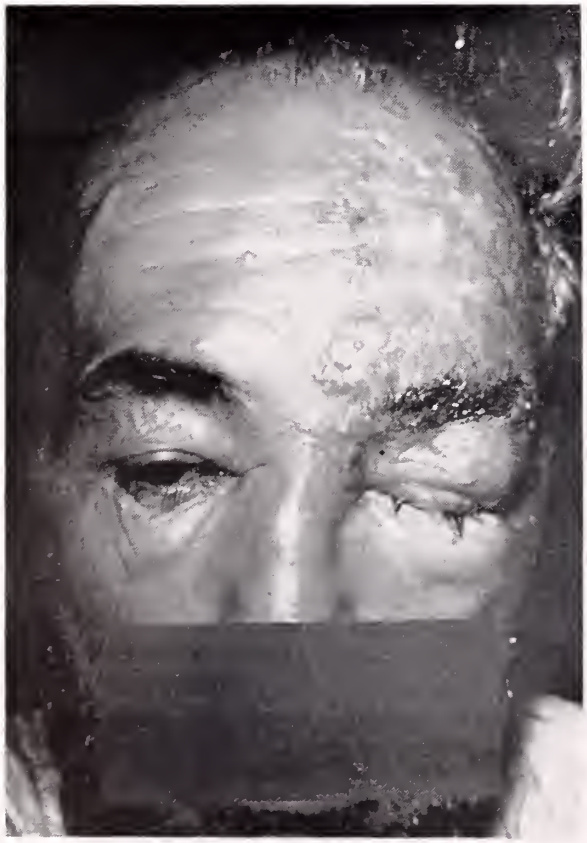


Figure 1—Case 1. Herpes zoster ophthalmicus, untreated, in a 45-year-old white male (see table).

Figure 2—Case 2. Herpes zoster ophthalmicus, untreated, in a 75-year-old white female (see table).

therapeutic measure in the treatment of ophthalmic herpes zoster.

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# No Miracles, Please

There is a generation of doctors, many of whom are still living and not a few of whom are still active, who have bridged the gap between the kindly if somewhat empiric medical practice of a half century ago and the modern ultrascientific and generally impersonal application of the art. To belong in this category and to have attained some of the characteristics of elder statesmanship one must have been born not too near the end of the last century and yet have been progressive enough to have moved along with the times.

Out of this group, whose representatives can still recall the difference between a martingale and a whiffle tree and to whom traces may indicate the straps by which a horse draws a vehicle, as well as something found in the urine in minute quantities, a number of medical historians of the period have been drawn. One of the most recent as well as one of the most distinguished of these recorders is Sir Heneage Ogilvie, noted as a British surgeon and now equally well known as senior editor of the Practitioner.

*No Miracles among Friends*, published late in 1959, by Max Parrish and Company of London, is actually a series of essays by Sir Heneage, humorously reminiscent and philosophically sophisticated. Two chapters, for instance, are given over to the "Use of Experience," as valuable as the uses of adversity, with less of the bittersweet characteristic of the latter.

Sir Heneage is a cosmopolitan person, having spent his boyhood in Chile until the age of eleven, then finishing his education in Britain and Munich and finally hanging his hat at Guy's Hospital, where it still remains. Time has been taken out for six months' service in the first Balkan War, five years in World War I, six months to recover from a motor accident and six years in World War II.

Parts of these interludes gave him the opportunity to appreciate the value of intermittent periods of idleness when the mind can remain fallow, allowing it "to sort and reassess its recently acquired treasures, and to readjust its spiritual values." The loss of his general surgical practice in 1937 as a result of six months' idleness recuperating from his automobile smashup was a fringe benefit; it was gradually replaced by a consultation practice of a higher order, which reached its zenith just in time to be in turn shattered by World War II.

From such experiences came the aphorism that neither the genuinely idle person nor the perpetually busy one is likely to get anywhere. Out of such a philosophy came Sir Heneage's chapter on the importance of leisure and probably also that in praise of work. A final chapter, "Journey's End," on the eventual rending of the veil, gives intimations, if not of immortality, at least of a peaceful release of the soul from its physical bondage.—The New England Journal of Medicine.

# Regional Orthopedic Diagnosis*

*William B. MacCracken, M. D.*

It is my purpose to discuss with you some of the factors in making a specific orthopedic diagnosis. As in other branches of medicine, this is completely essential to proper treatment. Let us consider two common complaints: shoulder pain and back pain. I would stress the fact that exact history-taking is at least as important as clinical examination, x-ray study, or laboratory examinations.

### Bursitis Unique Clinically

The patient who presents himself with the complaint of shoulder pain more often than not offers the diagnosis of bursitis. This, however, is the last diagnosis to suspect because it is the least common. Bursitis is an acute inflammatory lesion that is unique clinically. Pain is severe and constant, and tenderness is so exquisite that the patient usually will recoil before actual contact has been made by the palpating finger. The area of discomfort is localized to the region of the subdeltoid bursa.[1] The patient will localize the pain and tenderness quite well and will not complain of radiation into the cervical region or distally down the arm. The pain is markedly increased by any shoulder motion and the arm is held immobile, generally with persistent muscle spasm.

From the acute inflammatory nature of the pathology, free fluid is always present within the bursa. On occasion this may be detected by inspection but, more commonly, can be ascertained by palpation if the examining fingers are sufficiently gentle. In the uncomplicated primary bursitis x-ray studies will show no abnormality except possibly soft tissue thickening.

### Tendinitis

The condition most frequently presenting at the shoulder itself is not bursitis but tendinitis. This commonly goes through phases of pain with use and may finally become constant and aggravated by all motions. Tendinitis is a degenerative change in one of the tendons of the shoulder region, most commonly in the supraspinatus.[2] It is next found in the other muscles of the tendocapsular cuff, namely, the infraspinatus and teres minor. It may be present in the tendons of the subscapularis or pectoralis major. The end result of this degenerative change is calcification within the tendon, which can be visualized by x-ray and localized by careful clinical and x-ray examination.

In tendinitis the pain does not radiate into the neck but may extend distally to the midthird of the arm. Clinical examination in this condition tends to show well localized tenderness at the site of pathology. By well localized, I mean that usually it can be identified as being in one tendon rather than in an adjacent tendon. Since differentiation involves as little as a half-inch separation, extremely careful palpation and evaluation are necessary for proper localization and treatment. X-ray localization of calcium deposition often is less specific, and for proper treatment it seems best to rely on clinical evaluation.

While tendinitis is a specific pathological change giving localized symptoms and physical findings, when calcification is present there may be complications which change the clinical picture markedly. The simplest of these is rupture of the calcium through the superior surface of the involved tendon so that it lies beneath the floor of the subdeltoid bursa. In this position it is so irritating to the bursal lining that typical acute inflammatory bursitis becomes the predominant clinical picture. The combination of these two conditions should always be borne in mind, for the treatment must be based upon an exact diagnosis.

The most dramatic complication of calcaneous tendinitis is actual rupture of the calcium deposit into the subdeltoid bursa. This is fortunately an extremely rare condition, and one most painful to the patient. It gives a typical x-ray picture showing calcium throughout the extent of the bursa.

### Rupture in Tendocapsular Cuff

While any of the conditions discussed thus far may give some vague or inadequate history of

***The Author.***

- **William B. MacCracken, M. D., orthopedic surgeon of Huntington, died on February 29, 1960.**

*Presented before a meeting of the Association of Surgeons of the Chesapeake and Ohio Railway, at The Greenbrier in White Sulphur Springs, November 23, 1959.

Submitted to the Publication Committee, December 22, 1959.

injury, the most common condition following a definite and convincing injury is rupture in the tendocapsular cuff. This, again, is most common in the supraspinatus but may occur in the infraspinatus or teres minor. In the other muscles about the shoulder, it is relatively uncommon except in the tendon of the long head of the biceps. Typically, there is minimal pain at rest but fairly marked pain on attempting abduction, and marked loss of shoulder joint function.

This is a very interesting physical situation that has been explained in the past by the statement that abduction of the shoulder could be initiated only by the muscles of the tendocapsular cuff. Following this initiation, the deltoid was assumed to take up function and continue active abduction. It seems more reasonable to assume that all the abductor muscles work in conjunction. When one is damaged, as in supraspinatus rupture, function of the group as a whole is reflexly inhibited by pain on attempted use of the torn supraspinatus. Because of this there is entire loss of abductor function. When rupture is present, tenderness is quite well localized and passive motion produces pain most markedly when the involved tendon is put under the greatest tension.

As already stated, a very careful history is essential to diagnose the actual pathology when the presenting complaint is shoulder pain. In our experience, shoulder pain, more often than not, is the result of nerve root irritation in the cervical spine. The patient will not commonly offer the radiation of pain in a casual history, but will speak only of the region of maximal discomfort. He therefore must be questioned as to whether or not the pain extends up into the cervical and occipital regions. If it radiates down the arm, he must be questioned as to how far, and if into the fingers, which fingers. If we believe the pain to be of nerve root origin, there are many possibilities.

### 'Whiplash'

In the overly publicized whiplash injury, there usually is shoulder pain, but in this condition neck pain is more commonly the chief complaint. Malingering or functional overlay is almost always present, but these factors should not confuse an examiner with much railroad experience. The typical ligamentous strain or rear end car injuries can produce cervical spine pain that may be present constantly or present only with activity. It may produce any pattern of radiation, most commonly to the occiput or even frontal region, or into the face. Shoulder girdle and interscapular pain are more common than further radiation down the extremities. There may be paresthesia in the upper extremities giving the apparent paradox of the complaint of pain and numbness at one and the same time. Typically, these patients exhibit pain and spasm on motion of the cervical spine, diffuse ligamentous tenderness and diffuse nerve root tenderness. Pressure over the anterior scalene muscle, pressing as it does on the entire brachial plexus, reproduces or exaggerates the distal distribution of the pain.

### The Arthritides

Much shoulder pain is on the basis of arthritis of the cervical spine. Rheumatoid and gouty arthritis require further history taking. Their symptoms are commonly intermittent and often other joints or regions are involved. Rheumatoid arthritics will tend to have their most marked pain on arising in the morning, or after other periods of inactivity and circulatory stasis. Exposure to cold and damp will characteristically increase their symptoms. They commonly give at least the additional history of stiffness and puffiness of the fingers on arising in the morning. Unless the disease is marked, x-rays will show no changes except fusiform soft tissue shadows about the proximal interphalangeal joints of the fingers. The sedimentation rate will be elevated but a positive RA test is usually found only when the diagnosis is already obvious.

People with gouty arthritis often are difficult to identify except by very careful investigation. They may or may not give a previous history of migratory multiple joint pains. They actually have no definite history except for pain and upon occasion they may show no abnormal physical findings. Their symptoms may be brought on by injury and this may be of very trivial nature. Gouty arthritis must be considered in any patient with pain but without definite indications of any other condition. An elevated blood uric acid is suggestive, but of no value unless accompanied by an elevated sedimentation rate. Diagnosis can be completely established only by a therapeutic trial with colchicine, preferably given intravenously. Contrary to some teachings, gout is no respecter of sex.

Osteoarthritis of the cervical spine frequently produces shoulder pain as the presenting symptom. When carefully questioned, the patient may or may not admit pain in the cervical region without any further radiation of pain down the arm. As in other types of shoulder pain of nerve origin, stiffness of disuse may be present in the shoulder without this meaning that the basic pathology must be in the shoulder. Commonly, these patients have relief with rest and aggravation of the pain by activity. As a rule, there is

some limitation of motion in the cervical spine without definite pain or muscle spasm. There may be only minimal and unconvincing tenderness in the spine. There seldom will be any shoulder tenderness. Perhaps the most common sign will be reproduction of the shoulder pain by anterior scalene pressure. X-rays will show degenerative changes. Cervical traction generally gives definite relief.

### 'Frozen Shoulder'

The condition known as "frozen shoulder" has been a perplexing pathological phenomenon for many years. Although it has been well recognized as a symptom complex, the actual pathology has not been understood. The condition runs a very typical clinical course in which there is, at first, full shoulder motion with pain at the extremes. Following this, motion becomes limited in all directions, often first in internal rotation. There still is pain at all extremes of motion. Gradually the pain becomes more constant and of more diffuse nature and shoulder motion more limited. Finally the patient is miserable, with constant aching pain both day and night, and progressive limitation of motion and increase of symptoms on attempted motion. Physical findings are scant except for limited motion and mild, diffuse tenderness most marked usually in the bicipital groove of the humerus. Since the pathology has been unknown, treatment often has been disappointing, to the extent that some observers have advised against treatment.

Possibly, however, we are now coming to a better understanding of this syndrome. A recent study was started, based on the premise that the pain was of neurogenic origin and the limited motion of secondary nature. There is strongly suggestive evidence that the origin of the pathology is in the passage of the suprascapular nerve through the notch in the upper border of the scapula under cover of the transverse scapular ligament. A nerve lesion at this site would fit in well with the distribution of pain of which these patients complain.

In a small series of cases, temporary relief has been afforded by injection of this nerve with novocain and hydrocortone. In a few cases, exploration of the nerve has been carried out, and there has always been found edema of the nerve to the extent that it was indented superiorly by the transverse scapular ligament. There is no report of surgical exploration without preceding nerve injection, so one questions if the injection is related to the edema later found. The authors, however, report immediate and complete relief of pain by removing the transverse scapular ligament. They state that the relief is lasting and that improvement in shoulder motion is rapid and spontaneous.

### Cervical Disc

The patient with cervical disc protrusion often has shoulder pain as his presenting complaint. There frequently is neck pain and radiation to the finger tips, most often the thumb or the index or middle finger. Pain is often intermittent and influenced by posture. The patient more often feels that it is aggravated by shoulder motion and has not noticed any change with neck motion. Intermittent subjective numbness of the painful fingers frequently is present. Clinical examination usually will show radiation of pain when the spine is at once hyperextended, bent to the painful side, and compressed. The simple test of cervical traction, which may be carried out manually, often will give definite relief of symptoms. Oftentimes there is radiation of pain from pressure over the nerve root involved, practically always between C5 and C7. Anterior scalene pressure reproduces the pain. There is diffuse tenderness in the muscles of the extremity and, often, sensory changes in arm or forearm. Coughing or sneezing are less apt to increase the pain than in lumbar disc protrusions. There may be spinal cord pressure giving neurological changes in the lower extremities.

### Lumbar Pain

Let us now consider the field of lumbar pain which may be with or without radiation. Here the patient usually has seen his urologist first, but new feels the diagnosis is slipped disc. We will begin, however, with acute or chronic ligamentous strain at the lumbosacral joint, the most common cause of lumbar pain. Lumbar pain may follow injury or may come on spontaneously. It may or may not be accompanied by sciatic pain; it may be constant in nature or present only with activity. The typical clinical findings are pain at the extremes of motion, especially hyperextension. The most common finding is well localized tenderness at the lumbosacral joint, there being little if any sciatic nerve tenderness even when sciatic radiation of pain is present. Radiation of pain, if present, probably is referred from irritated nerve endings in the synovial lining of the apophyseal joints. If straight leg raising seems to be painful or limited, it must be carefully compared with the opposite side, for many people do not differentiate between the discomfort of muscular tension and actual reproduction of their sciatic pain.

A second common cause of lumbar pain is labelled "myofascial tear," although this may be

a misnomer. The symptom complex more commonly arises following a specific injury but may arise with no known injury. It may be acute or chronic. The pain may be constant or only with motion. As a rule, it is not in the mid-line but to one side. There may be some vague sciatic radiation, or there may be rather marked radiation to the inguinal region.

Examination ordinarily will show pain on flexion and contralateral bend but not on bend to the painful side. This may not always be true if the muscles on the concave side do not relax, so the motion should be forced passively by the examiner rather than carried out actively by the patient. Well localized tenderness usually is found at one of two common sites. The first is the tip of the third lumbar transverse process, and pressure here often will reproduce inguinal radiation of the pain, probably because of the proximity of the tip of the third transverse process to the path of descent of the nerves from the dorsolumbar level. The second site is the inner aspect of the posterior superior iliac spine. It is from a lesion at this point that vague sciatic pain may be referred. At either site the diagnosis is best established by local novocain injection.

#### Diagnostic Novocain

When using novocain as a diagnostic test, the results must be carefully evaluated, lest they become a very confusing red herring. There is much literature suggesting trigger points in relation to lumbosacral and sciatic pain. By this the meaning always has been a point of actual primary pathology which initiates whatever painful syndrome is under consideration.

Nerve root irritation, however, can produce pain in any region of the nerve distribution, and need not be in the entire region of that nerve root distribution. At any point where one can press his finger on a nerve filament from an irritated nerve root marked local tenderness can be demonstrated. If this nerve filament is injected with novocain the entire symptom complex will stop, for this injection may be from the actual origin of the pain. One cannot stress too strongly that this relief of pain from novocain injection in no way proves that the injection was made at the site of actual pathology. Only lasting relief of symptoms will prove this.

#### Lumbosacral Pain and the Arthritides

In considering lumbosacral pain with or without sciatic radiation, one must constantly remember the arthritides. Marie Strumpell arthritis is uncommon, but it can occur in either sex, through a great age range, and produce symptoms long before the x-ray picture is marked or typical.

The usual type of rheumatoid arthritis is much more common and can give almost any clinical picture of lumbar and nerve root pain. If this condition is suspected, one must inquire about other joints, migratory symptoms and especially about finger symptoms. The relation to activity and rest must be known as well as reaction to weather changes. If one suspects an inflammatory arthritis at all, the possibility of gouty arthritis arises. These conditions give pain on motion, tenderness will not necessarily be well localized, and there will be little if any nerve tenderness, even though sciatic radiation of pain may be extremely marked.

In the older age groups, osteoarthritis is a very common finding in the lumbar region. At the lumbosacral joint itself degenerative change is apt to occur early because congenitally poor structure is so common at this level. In the strenuous occupations, diffuse arthritic changes may develop early due to the constant multiple traumata of their occupations. Symptoms may be quite variable and with or without radiation, but the common factor is relief by rest and aggravation by activity. With localized changes at the lumbosacral joint, there usually is localized tenderness here, but in the diffuse form there often is no tenderness or, at least, no tenderness comparable to the degree of symptoms, or to the extent of x-ray changes.

#### LS Pain Secondary to Nonspecific Prostatitis

There is another type of lumbosacral pain not common and not well understood. It is secondary to nonspecific prostatitis. Here the complaint is of fairly well localized lumbosacral pain, present after rest and relieved by activity. These patients will complain of great difficulty in putting on their shoes in the morning but may well have complete relief with the activities of the day. Many will have pain coming on after six or seven hours in bed and be required to arise before their desired hour for relief of symptoms through activity. Some even will have recurrent pain and stiffness after sitting down during the lunch hour. In checking for prostatic infection in these patients, it must be remembered that a first prostatic massage may produce no pus, whereas repeated massage one week later will show it very clearly. These patients often will have prompt relief of symptoms from the first massage. From the standpoint of orthopedic examination, they commonly show no abnormality other than pain on motion, and this too

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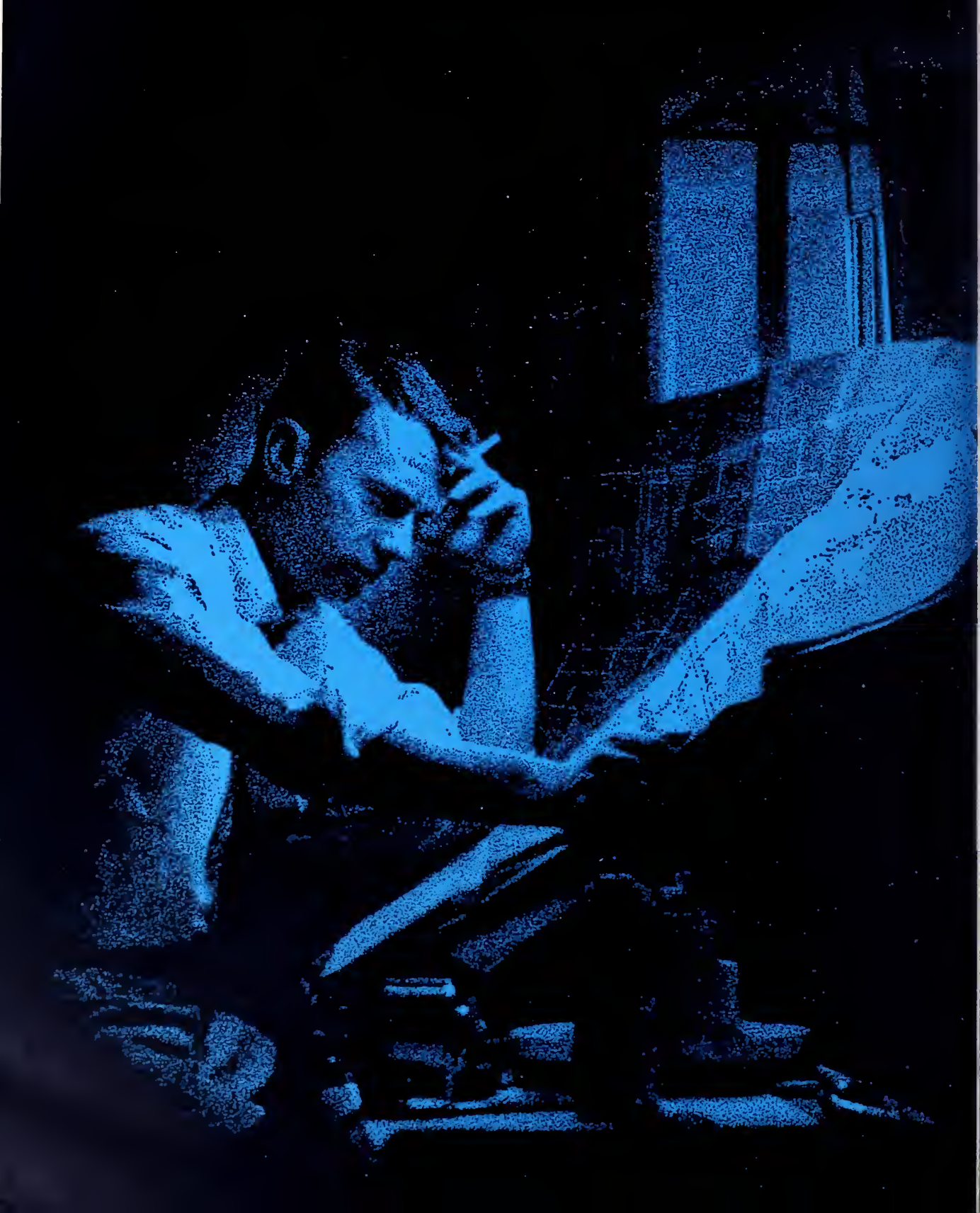

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may be entirely absent at the time of the examination.

### Protruded Lumbar Disc

Lastly, I shall discuss briefly the lumbar disc protrusion syndrome. This diagnosis in some quarters seems to be almost as universal for low back and sciatic pain as the diagnosis of bursitis for shoulder and arm pain. I cannot stress too strongly that herniation of an intervertebral disc in the lower lumbar region is merely one of many pathological conditions that may be found there, and that the diagnosis is one which should be made only on adequate grounds. Unfortunately, the disc herniation syndrome may follow many patterns and may be apparently spontaneous as well as following specific trauma. The most common pattern, however, is lumbosacral pain following injury but not accompanied by sciatic pain for some variable period of time. Gradually, pain develops to the ankle region or into the entire foot and some of the toes. With this there may be intermittent numbness in the distribution of one dermatome or in the entire extremity. The pain often times is increased by elevation of spinal fluid pressure, as in coughing, sneezing, or straining at stool. The patient frequently describes limited straight leg raising, such as when he states he cannot bend forward without elevating his leg to the rear, or he cannot get it down flat when sitting in the bathtub.

On examination, there may be a list of the trunk to the forward and to the painless side, or the patient may show merely marked obliteration of the usual lumbar lordosis. Hyperextention and lateral bend to the affected side, however, tend to increase the pain. The one real localizing finding is reproduction of pain radiation by pressure over an interlaminar space about one inch from the midline. This actually is pressing in the ligamentum flavum so that the nerve root is squeezed between it and the protruding disc. In more marked cases, or cases of longer duration, there may be reflex or sensory changes, and there may be atrophy and muscle weakness in the calf. All these, however, are not necessary for the diagnosis. X-rays give no suggestion of disc herniation as the disc material is not radiopaque and there is no connection between thinning of the intervertebral disc space and disc herniation. Myelograms may be helpful in establishing the diagnosis but I believe clinical examination can be more reliable.

### Conclusions

I would like to leave with you several specific thoughts. Very little shoulder pain is due to bursitis and most shoulder pain is of nerve root origin. Disc herniation in the lumbar region is not the commonest cause of low back and sciatic pain. Nothing more than pain is needed for one to consider the possibility of gout. Novocain can be a misleading diagnostic agent. And, most important of all, a thorough and carefully elicited history can be your very best diagnostic aid.

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# Broader Plan of Medical Training Sought

It has always seemed to me that the training of doctors in medical schools should be focused on the most commonly occurring disease. After a study of normal structure and function and the various major pathological deflections young doctors should be schooled in the most commonly occurring diseases they will meet in practice. This, of course, is not to infer that we recommend inattention to the other less frequently occurring conditions.

The curriculum of medical schools is heavily beset with problems in the selection of just what to teach the students. Indeed there is now taking place a re-examination of the whole philosophy and program of medical education in an endeavor to reorganize training so that graduates will have a much broader understanding of the whole range of medical problems.

Concentration on minute details of bacteria, organ dysfunction, electrolyte imbalance and specialized conditions to the neglect of the patient as a human being has left much to be desired. However, there is this re-examination and experimenting with various innovations in curriculum in the hope that, in the not-too-distant future, a broader plan of training may result.—Edward L. Bortz, M. D., in Transactions & Studies, College of Physicians of Philadelphia.

# Steroid Therapy in Dermatitis Venenata

## (With Case Reports)

*Abraham Tow, M. D.*

The use of steroids topically has found favor in many dermatological conditions, but there seems a hesitancy in giving these hormones orally. It is for this reason that two cases of dermatitis venenata, so treated, are deemed worthy of report. The result with small doses of dexamethasone (Decadron) over a short period of time was rapid and astounding.

Case 1 was a five-year-old white male child admitted to the Man Memorial Hospital at 2:30 P.M., May 21, 1959. Past history was inconsequential. Four days previously, following play in the woods, a rash appeared on his body and legs. It itched. He scratched. That evening his eyes became red and lacrimosal. His face began to swell and the swelling gradually grew worse until his eyes could be opened only with difficulty. The rash on his body and extremities worsened progressively. Pain developed and medical advice was sought.

Physical examination on admission showed a well developed and well-nourished white male child with a severely swollen face. The left cheek from the eye downward was very edematous and there were several infected areas. A papular and vesicular rash covered the entire left lower cheek and extended well onto the neck and over the lower portion of the left ear. On the right cheek similar lesions were present but not so severe as on the left. There was an area of circumoral pallor about ¾ inch wide in contrast to the marked edema of the face. A scattered morbiliform rash covered the upper part of the chest. The left lower abdomen was extensively involved and a large part of this area was infected also. The left arm was involved, with the lower two-thirds swollen and showing a serous exudate. There was some swelling of the right arm but to a much lesser degree than the left. The lower two-thirds of the left thigh and the inner aspect of the posterior surface of this knee were also moderately involved.

Due to the impetiginous nature of the skin lesions, he was given penicillin G. 300,000 U. and Bicillin® 600,000 U. intramuscularly on admission and 400,000 units of Pen Vee K® every 6 hours, orally, from May 23 to May 28.

**Submitted to the Publication Committee, December 14, 1959.**

### *The Author*

- **Abraham Tow, M. D., Man, West Virginia.**

A course of dexamethasone was instituted immediately. The schedule follows:

| | *3:00 A.M.* | *9:00 A.M.* | *3:00 P.M.* | *9:00 P.M.* |
|---|---|---|---|---|
| 5/21 | | | 3 mg. | 2.25 mg. |
| 5/22 | 1.50 | 1.50 | 1.50 | 1.50 |
| 5/23 | 1.50 | 3.00 | 1.50 | 1.50 |
| 5/24 | 1.50 | 1.50 | 0.75 | 0.75 |
| 5/25 | | 0.75 | | |

The total dose was 24 mg.

The antibiotic took care of the pustular portions of the lesions and within 2 hours of the administration of the first dose of steroid the edema had noticeably subsided and the patient was no longer in pain. Within 24 hours he looked like a different child. The swelling of his face and the edema in other areas of the body had almost completely disappeared. His fretfulness was gone, the itching was mild, and he was well.

On May 23 he was given a 3 mg. dose at 9 A.M. because it was felt that reduction might have been too rapid. But the improvement was so continuous and progressive that this was not necessary again. Within 72 hours the lesions were healed.

Other adjuvants at our disposal were employed symptomatically to hasten the return of the skin to a normal texture. Metiderm Aerosol® was used locally on two different occasions to control itching. Bathing with Aveeno® colloidal oatmeal was done on May 21, 22 and 23. Tridenol® was put in his bath water on May 25 and 26. Aveeno® ointment was used locally on May 26, 27 and 29. The patient was discharged on May 29 with a few roughened areas of the skin on the inner surface of his thighs but elsewhere it was soft and silky with no vestige of the original rash.

Case 2 was a 9-year-old white female who was admitted May 20, 1959, late in the evening, with a history that on the afternoon of the preceding day she had picked roses in the woods.

The next day she developed a rash on the body and extremities which itched. Later that evening her face became markedly swollen and she was admitted to the hospital.

It is felt that she scratched the lesions on her hands and feet and spread it to her face which was swollen so that it resembled a full moon. The right eye was completely closed but the left could be opened slightly. There was a marked morbiliform rash over the face and neck, and around both wrists. Some of the rash here was also red, raised, confluent and almost plaque-like in consistency. There was a morbiliform rash on the trunk. The lower extremities were essentially free of the rash except for an occasional patch here and there on the legs similar to that on the body. There were scattered, discrete papules between the fingers of both hands. The rest of the physical examination was negative. So was the past history.

On admission she was given 40 mg. of Benadryl® intramuscularly and then 25 mg. every 4 hours by mouth. There was no improvement in her condition the next day, but the Benadryl® was continued 5 times daily for 3 days. Buccal Varidase® was suggested and she was given 1 tablet every 6 hours for four doses.

She was also given 1 injection of 0.3 cc. of Adrenalin in oil 1:500 to relieve her intense itching. After the first dose of Buccal Varidase,® the shiny edema about her eyes lessened noticeably but with successive doses of the Varidase® there was no change. On May 22, 36 hours after admission, she was started on dexamethasone (Decadron®) as follows:

| *Date* | *3 A.M.* | *9 A.M.* | *3 P.M.* | *9 P.M.* |
|---|---|---|---|---|
| 5/22 | | 3 mg. | 3 mg. | |
| 5/23 | | 3 mg. | 2.25 mg. | 1.50 mg. |
| 5/24 | 1.50 mg. | 1.50 mg. | 0.75 mg. | 0.75 mg. |
| 5/25 | | 0.75 mg. | | 0.75 mg. |
| 5/26 | | 0.75 mg. | | |
| | | Total 19.5 mg. | | |

Following the first dose of Decadron,® the improvement was very noteworthy. Within 2 hours her face had decreased in size noticeably and the rash on the rest of her body had improved considerably. The improvement was constant and progressive so that by the evening of the 24th her face was almost normal and the rash on the body was much improved. By May 25 her face, extremities and abdomen were normal except for small residues of the rash on her fingers and an occasional patch on the body. Baths with Aveeno® Colloidal powder were given and Aveeno ointment® was applied locally during the day and these were of considerable assistance in hastening the restoration of the skin to its normal appearance. Meti-Derm Aerosol® also was used on occasion to lessen the itching and to facilitate the return of the skin to normal.

**Summary**

Oral steroid therapy in 2 cases of severe dermatitis venenata produced complete recovery after 5 days of therapy. A total of 24 mg. of dexamethasone was given in 1 case and 19.5 mg. in the other.

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# The Importance of Not Being Too Earnest

Do you wear the proper dignity of the profession—take your work seriously—compose the sober enigmatic expression—knit your brows in circumfacial pallor—pace methodically with hands rigidly entwined behind the fifth lumbar vertebra? Do you deeply contemplate when the life-determining decision is in balance? Are you a clinico-diagnostic beagle and a therapeutic brooder? If so, you are probably a first rate doctor, although you may miss the race by a nose for first place.

Even under the most dire circumstances, a small glint in the eye, a non-dire risor sardonicus, a slight rise to tenor from the usual basso precision may save the day. All too often the dignified and artfully tempered swagger of the coat-tails could be modified to allow a ray of sunshine to penetrate the lugubrious functions of the scientific mind, and with acceptable graciousness, raise the morale of the somewhat bewildered patient.

Beware the move of catastrophic, significance, the calculated wrinkle fraught with prophecy; have a sense of humor, relax your lumbar curve, enjoy your work and show it.—Westchester Medical Bulletin.

# The Emotional Needs of Children

*David M. Wayne, M. D.*

PREVENTIVE medicine has accomplished wonders in the control and prevention of many forms of illness which at one time were widespread. The need is now great for public health workers to turn their efforts in the direction of finding ways of preventing emotional maladjustment during the developmental years of childhood. Mental illness is our number one public health problem in the nation. It is a local public health responsibility. We must have as great an awareness of the importance of preserving mental health as we have in preserving physical health in our communities. If it isn't both physical and mental health, it just isn't public health.

### Environment

A human being is no healthier than his environment. If he lives in an environment where there is lack of proper sanitation, his chances of avoiding illness are obviously less than those of persons who live where sanitation and public health are good. In the same way, an individual's personality and mental health are no better than the emotional environment in which he lives.

We are vitally interested today in the emotional stability of the school child. Three million children suffer from emotional and behavior disorders and 400,000 children are brought into the juvenile courts each year. Every child must have an opportunity to grow up physically and emotionally healthy. How he comes to feel about himself is highly significant to his future. The Bible states "Thou shalt love thy neighbor as thyself." This clearly indicates a need for a positive feeling about self as a basis for a constructive attitude toward others. In order to love his neighbor one must first develop the capacity for loving one's self. Self-respect and self-confidence result from being respected, liked, wanted and trusted by significant people in our childhood. This is tremendously important to emotional health throughout life. It is only through our actions in their behalf that children know how they stand with us. Psychiatric patients have disturbed, unhappy and sick feelings about themselves which result in difficulties in interpersonal relations. If you are brought up with people who like and trust you, you easily come to like and trust other people.

Submitted to the Publication Committee, December 9, 1959.


## *The Author*

- **David M. Wayne, M. D., Bluefield Mental Health Center, Bluefield, West Virginia.**


### Normal Emotional Growth

Today, rather than waiting for behavior disorders to develop, we are seeking to understand normal emotional growth. Psychiatry has learned a great deal about normal growth of the personality from the helpless dependency of the infant through the selfishness of childhood to the mature adult who is self-supporting and contributes to society. This is a very complicated process and has many pitfalls. Restrictions and frustrations are inevitable in a child's development and how he learns to meet them is of utmost importance for the development of a healthy personality. Personality development follows biological principles. It is a biological principle that everything that grows follows a certain ground plan that is laid out at the start. Out of the ground plan the parts arise, each part having its own time for maximal development. If a part fails to achieve maximal development at the proper time or is severely damaged during the formative years, it is apt to interfere with the functional harmony of the whole. In personality, instead of development of organs, there is development of a sense of values, social capacities and a way of dealing with experience.

### Affection, Acceptance and Achievement

In order to grow healthy and strong, every child should have food, plenty of fresh air, exercise and sleep. Children have emotional needs too, and every child also requires a balanced emotional diet. The important ingredients of an emotionally balanced diet are the three A's: affection, acceptance and achievement. There is no doubt that the most essential emotional food every human being requires is love. Love lays the foundation for emotional equilibrium but love is not enough; it must be unconditional love. By unconditional love is meant just that; love without any strings attached. A child needs to know that no matter what his shortcomings may be, he is a satisfactory person. He needs to know

that there are people near him who care what happens to him, that he matters very much to them, and that they love him for himself just the way he is. One way of getting over to him that he is a satisfactory person is to feel proud of him as a person doing his best. Making believe about our inner feelings just doesn't work. Surface acceptance is not enough. Children see through it. You can't fool any of them. Showing interest is another way of expressing love. If we are really interested in our child, we must tune in on his special frequency and be sensitive to his hurt feelings. Most parents usually pay attention to the clothes children wear, whether they wash properly or brush their teeth. How many are alert to their emotional needs and their feelings? The parent who has confused feelings is hardly in a position to guide a child in the direction of emotional stability.

An important emotional food for all children is the feeling of acceptance. Every child needs to feel that his parents accept him all of the time, even though they often do not approve of the things he does. Every child needs to know that his parents will always be on hand, especially in times of crisis when he needs them most. The very important function of any parent is to be a safe port in a storm where a child takes refuge when the going gets rough. The child needs love when he is least lovable.

Another emotional food is achievement, feeling that one is capable. All of us know how important this is if we have ever experienced any of the dreadful moments at a job, or at home when we felt incapable of doing what was expected of us by ourselves or others. Parents too often expect a child to accomplish things beyond his ability. Some children have limited intellectual endowments and cannot fulfill a parent's wishes. It is important that parents recognize intellectual limitations in their child and be satisfied with the best the child can do. We often see a vicious cycle starting with emotional problems leading to poor grades in school. This produces increased pressure at home to improve the grades which in turn produces more emotional problems.

#### Significant Deviation in Behavior

Any sudden deviation in the usual behavior of the child is significant and merits attention. For example, a child goes to church regularly and suddenly refuses to attend, or he suddenly indicates that he no longer likes school when he was formerly a good student. When a child misbehaves, it should serve as a message which reads, "I am hungry for more love, I need you to understand me more deeply," or "I need more chance to achieve." Whenever we are faced with misbehavior in our children, we should ask ourselves the following questions: Are we making impossible demands? Are we hurting our child's self-respect? Are we too quick with blame and to find fault and too stingy with praise and encouragement?

You may criticize a child's work but not his personality. Don't ever give the child the idea that anyone is perfect. Everyone makes mistakes. Don't label children. Beware of labels such as lazy, stupid, slow, bad or dirty. If you do have to label a child, give him one that makes him part of a group rather than something that tears him down or pulls him apart. Whenever you stop him from doing something, make it clear that you understand. For example, you may say to a child, "Johnny, I know you are angry with me because I won't let you run in the hall. Now it is all right to be angry but I can't let you run in the hall because it is too dangerous." All children have feelings and it is important to let them know that having feelings is all right.

Misbehavior may also be a way a child has to give vent to his bad feelings. He has to learn better ways of accomplishing this. If you are to teach him this, you must help him admit his feelings and face them. More obviously he cannot steer what he cannot see. One of the biggest steps in helping a child get rid of bad feelings is to enable him to bring them out to you. If the bad feelings are let out, there is more room for good feelings. When they are let out and accepted with understanding, good wholesome feelings often flow in spontaneously. Now, don't misunderstand me, the fondest mother occasionaly becomes impatient and irritated with a child whom she loves, accepts and approves. The very fact that she can afford nonrepressed feelings of the moment is a manifestation of secure relations with the child. It is, therefore, not so much the individual occasional irritation or the method of correction at the moment that counts but the sum total of the over-all attitude toward the child.

Difficult childhood experiences should be lived through and resolved, leaving a positive feeling in the relationship rather than allowing it to persist as a chronic, unsatisfactory interpersonal relationship. It is also well to remember that feelings leave memories. Some of the feelings that influence our present behavior belong to past experiences rather than to the situation at the moment. In order to understand properly a child's behavior requires a study of how he feels rather than the merits of the immediate situation.

Healthy human relationships are the best assurance to healthy emotions. This means that our own emotional health is a primary consideration in our ability to give healthy experiences to others.

### Discipline

Discipline is necessary for the orderly emotional development of the child. It is also a very necessary requirement in our society. We must try to understand discipline in terms of present day culture in our own country. Our culture stands for restraint, renunciation, sacrifice and long-term strategy. Restraint, renunciation and gratification postponement are nothing more than self-discipline. Any form of discipline on the part of the parents should be done with the aim in mind of developing self-discipline in the child. The parents must look upon discipline as an educational process by which the child will be led to independent self-discipline. Specific techniques of discipline are less important than the spirit of the relationship which exists between the child and the parent. Honor thy father and thy mother must not be expected merely because one is a parent. It must be won on merit. The art of discipline lies not in the specific details of what one does as in the feeling tone behind it. The parent who has a proper feeling toward his child is not afraid to act decisively. It is a feeling that parents give to children, not things or possessions, that will determine the child's health, happiness and future success. Children in general desire approval and like to conform. His own individual personality is influenced by the extent to which he accepts the do's and conforms to a world of don't's. The do's and don't's in the life of a growing child must be repeatedly brought to his attention and he will learn to accept them. The child seeks love and security, and discipline will accomplish its purpose if it is underwritten by a feeling of love and security in the child's relationship to the parents. Just as a society cannot exist without discipline, so a child is unable to develop into a socially normal individual without self-discipline.

Discipline is important to the child for the following reasons: He needs to know how far he can go, since knowledge of where the limits are gives him a feeling of security; our society demands certain standards of restraint and self-discipline and he needs to live according to these so as to avoid guilt feelings; discipline serves as an indispensable factor in the development of the child's conscience.

### Helping Children With Their Difficulties

Isolated incidents do not disorganize human personality. There is usually a long period of difficulty, struggle and frustration before any serious trouble develops. This means that there is plenty of time to give help if early indications of difficulties and struggles are watched for. It is worthwhile helping children with their difficulties even though most of them could struggle through to some type of adjustment without help. Little is gained by insistence on superficial conformity if it serves only to mask angry, defiant feelings within. Suppression of feelings drives them deeper inside rather than permits them to come out. Repressed tensions and unexpressed feelings are buried alive and neurotic symptoms result from an effort to escape in disguised form the outlet denied them in their original form.

The significant question to ask about any child is: "Is all well in this child's life?" rather than, "Are there signs of serious trouble?" By keeping alert to the child's physical and emotional health you automatically improve his health prospects. Helen Spears Burgess states, "If we can stop thinking of children as good or bad but as learning, if we can interpret our values in terms of what is understandable to a child, the discipline problem will dissolve into a splendid process of learning how to live. The doors of life are wide open for a child who knows that there are adults who will help and guide him when he needs it, but at the same time allow him to go ahead on his own because they have confidence in him."

### Summary

1. A human being is no healthier than his environment. In the same way an individual's personality and mental health are no better than the emotional environment in which he lives.

2. It is important that parents have a sense of integrity. Likewise all who deal with children must have a good sense of moral values and ideals.

3. The greatest gift that a child can receive from his parents is love and understanding. Personal love and understanding are extended outward from himself to love and understanding that embrace all men.

4. The important ingredients of an emotionally balanced diet are the three A's: affection, acceptance and achievement. Love is not enough. It must be an unconditional love.

5. Discipline is necessary for the orderly emotional development of the child. Just as society cannot exist without discipline, so a child is

unable to become a socially normal individual without self-discipline.


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# Para

One characteristic of the mature mind is that its owner gains satisfaction from a multiplicity of sources. Winston Churchill, manifestly of mature mind, not only is Winston the statesman, but Winston the painter, Winston the historian, Winston the smoker. The plaint is that organized satisfaction pursuits often are expensive of time and money. Golf may be, or the collection of antique pressed glass. Some others call for no expenditure of money and scarcely any time. One in that category is the exploration of words. Words, like persons, nations and rivers, have histories. No one need be a philologist, etymologist or semanticist to be an amateur word explorer. All the equipment required is a dictionary and the inclination.

Take any word. Take any portion of a word. Take the common prefix "para." Hundreds of words in English, in and out of medicine, make use of para or its shortened form "par" as a prefix. It would be exceptional if any physician passed an entire day without encountering some para words. Daily most persons see scores of other persons whose faces are shaped in part by the parotid glands. But who in that total knows the simplicity of the origin of that word "parotid"? It means nothing more than the gland located near to the ear—"para," "near to," and "otos," "the ear."

In ancient Greek para had many usages. It meant "near to," "along side of," "derived from," "by," "beyond," "except." Through some shiftings about in the Italian and French languages, para took on the meaning of "protect from." On a hot summer's day, parasols may be seen here and there. Did curiosity never become piqued as why a parasol is called a parasol? It is no more than "para," "to protect from" and "sol," "the sun." So also parachute is "para," "to protect from," and "chute," "a fall." In this vein, paratyphoid is a disease like or almost typhoid. The parathyroids are organs alongside of the thyroid. Paranoia is the same para meaning, in this instance, "deviated from," the mental normal.

If something or someone is the perfect specimen, the term "paradigm" fits. Literally, the word means with its para prefix "showing up well alongside others of its kind." A closely similar word regarding being a model is "paragon." This means rubbed up against a whetstone. A paragon is someone polished up to perfection. Paracelsus is the Latin name of one of industrial medicine's heroes. Whence came this adopted name? Celsus was a famous Roman physician. His long later emulator, not content with Celsus, had to be greater. So he crowned himself Paracelsus.

Word exploration has its own boobytraps. Not all "para" words stem from an ancient prefix. Para-rubber does not mean near to, or like rubber. Para-rubber is the rubber that is obtained from the region of Para, a city in Brazil. Parakeet, the love bird, does not mean likeness or closeness to the keet, another bird. Parakeet, the entire word, springs from an origin that by free interpretation means a "Little Peter."

Seldom does an essay contain a built-in revenge. This one does. If there be scoffers and sneerers at the banality of word exploration, then at once all such may be charged with immature minds. For them, back to the baseball returns, "no runs, no hits, no errors"; or back to matching pennies with the janitor downstairs.—Industrial Medicine and Surgery.

# 93RD ANNUAL MEETING

of the

# *West Virginia State Medical Association*

## *The Greenbrier*

AUGUST 25-27, 1960

# The President's Page

## Mental Health in West Virginia

I THINK it behooves every member of the West Virginia State Medical Association to become aware of our mental health needs in this state. It was my pleasure to attend the American Legion Conference on Mental Health, held in Charleston on December 5, 1959. At that conference, Mr. Mike Gorman, Executive Director of the National Committee Against Mental Illness, gave the keynote address. At the same meeting our Association was well represented by Dr. L. J. Pace of Princeton, chairman of our Mental Health Committee.

These reported facts struck me as being important: That West Virginia's mental health program is one of the weakest in the nation; that according to a 1954 survey we need 88 more psychiatrists, 26 psychologists, 42 social workers and 465 more nurses in our mental hospitals alone; that we spend $1.90 per day to cover food, clothing, medical care and housing for each mental patient (the U. S. average in 1945 was $1.06 and in 1957 $3.65. In Veterans psychiatric hospitals the figure was $10.30 in 1957, and for general hospitals, $26.02).

The only things that have been accomplished since 1954 in West Virginia is to have another survey by the U. S. Public Health Service in 1958. The West Virginia University Department of Psychology has inaugurated a program for doctoral training of psychologists, and the transition of the medical school from a two- to a four-year curriculum with the possibility of the development of a strong Department of Psychiatry.

It has been recommended that general practitioners be trained in psychiatric skills. Here is where the Veterans Administration and the American Legion came into the picture and, according to Mr. Gorman, "it really saved the mental hospital program for the Veterans Administration." Now, will this work in West Virginia? Should the West Virginia State Medical Association, the West Virginia Academy of General Practice and the West Virginia University School of Medicine get busy and set up postgraduate courses for family physicians who desire additional training in psychiatry? If this is necessary, then let's be about it.

Personally, I can see many complications in such a program. First, who is going to train the general practitioners now? Once they are subjected to the training, how many are going to realize that they are not specialists in this field and should confine their activities to their qualifications? Lastly, how many general practitioners do we have in West Virginia who want to avail themselves of this training? I would hope that this program could become a reality.

The only solution for our present situation is for our Legislature to appropriate enough money, not only to house these patients, but to provide adequate treatment of this illness. To do this will necessitate the services of a good mental health team, the director of which must be a psychiatrist. Right here the law must be changed immediately so that the director need not be a resident of West Virginia to qualify for this important position.

It is going to take many years for the West Virginia University School of Medicine to provide trained personnel, in sufficient numbers to meet our needs. In the meantime, our State Medical Association should stand ready and willing to offer our assistance in the solution of this most important problem of mental illness. In addition, we should help in the establishment of diagnostic centers, intensive treatment centers, a program for alcoholics and better facilities for our mentally retarded children and adults in West Virginia.

If we are going to become leaders and advisors in this field, then we must urge Blue Cross and Blue Shield Plans to offer a deductible contract to cover mental illness. In addition to benefiting the patient, this would obviate the just objection of the psychiatrist to whom in the long run we must look for the final solution to the problem of mental illness in West Virginia.

J. C. Huffman, M. D., President

# THE WEST VIRGINIA MEDICAL JOURNAL

*Official Organ of the West Virginia State Medical Association*

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.



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*Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.*

*Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.*


# EDITORIALS

## ARE WE OUR OWN ENEMIES?

We are in receipt of a clipping from a recent issue of *The Fort Lauderdale News* in which Mr. Harvey A. Call, of whom we never heard before, editorializes on the imminence of socialized medicine and the responsibility of the doctors themselves for what he believes to be the impending enactment of legislation of the Forand or Kennedy type. Robert Burns must have "dipped into the future" and visualized Mr. Call when he wrote:

> *"O wad some power the giftie gie us*
> *To see oursel's as ithers see us;*
> *It wad frae monie a blunder free us."*

Mr. Call mirrors us to ourselves and accurately reflects our weaknesses and shortcomings; the things we could avoid, especially the multiplicity of Cadillacs, the transformation of medical *practice* into medical *business*, the disinclination to make house calls, the gradual evaporation of the milk of human kindness from the doctor-patient relationship, and a host of other ills which now beset us and becloud our future. To say that "the third party" has gummed up medical practice is to present only one facet of the situation. The "third party," as we see it, is here to stay and the sooner we realize that and begin to lead the third party, the less the third party will goad us into a wilderness where doctors will degenerate into mere employees and patients to pawns on the political chessboard of medical service.

We cannot agree with Mr. Call upon one point, or rather one implication. The quality of medical care is not poor. The medical care available to the average American today is better than it has ever been anywhere in the world, and it is improving all the time. Of course it isn't perfect, man being mortal, and never will be, in the predictable future at least. But medicine can well point with finger of pride to the enormous lengthening of the life span since the turn of the century; to the practical eradication of diphtheria and typhoid; to the marked decrease in pneumonia deaths; to the shortening of the hospital stay; to the diminution of maternal and infant deaths; to insulin, antibiotics and the thiazides, and to sundry other accomplishments of modern medicine.

Complaints against the quality of medical care are the product of ignorance of current medical progress, or the pipe dream of perfection, an ideal state which, as far as our knowledge goes, is still in the future in all fields of human endeavor.

Our thanks to Mr. Call. His editorial is so full of wisdom (and warning) that we reproduce it entirely elsewhere in this issue (Page 220). We hope every doctor in West Virginia reads it and then writes a letter to his congressman and both

West Virginia Senators protesting against any such legislation as Mr. Forand and Senator Kennedy would foist upon us.

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**THE AGED AND AGING**

The American Medical Association sponsored a special meeting in Chicago recently to discuss "Preparations for Medicine's Participation in the 1961 White House Conference on Aging." In attendance were representatives of the committees on aging of state medical associations, members of governor's committees on aging, and representatives of joint conferences on aging.

Seldom has any process in nature received such rapt attention from so many learned people of such wide distribution in our country.

Here it was pointed out that Aging is not something new, nor are there diseases limited only to the aged. People have grown old for centuries and the problems and privileges of the elders have served as themes for discussions throughout recorded history. But since Medical Science had helped to produce more and older aged in our population, the American Medical Association several years ago formed a committee to study the phenomenon and to meet its medical needs.

Groups in government decided that there was a problem of aging, and politicians sensed that there was a voting block of elderly persons. People were being forced to retire from work at certain ages and inflation was producing some financial problems for them.

Congress then decided to have a White House Conference on Aging and, under the Social Security Administration (now Health, Education and Welfare), set up the machinery for that Conference to be held in Washington in January, 1961.

The socializers then saw a splendid opportunity to get on the band wagon and perhaps even lead the parade, so with the help of Mr. Aime Forand a bill was introduced in Congress to provide medical, hospital and nursing home care for all recipients of Social Security by increasing the Social Security "take" from employers and employed. The socializers and some of the labor unions began in earnest to beat the drums for this legislation and consequently it behooved the representatives of honest medical practice, which had made possible much of this older aging, to point out again that Government Medicine of the Forand, or Socialist type, is still bad medicine.

To those of us in attendance at the Chicago meeting the following points seemed perfectly clear:

1. Doctors of Medicine are honestly concerned with the problems of their older patients and are working magnificently toward their solutions.

2. The so-called problem of the aging which is being so publicized and blown up is being used rather than helped by much of the ballyhoo.

3. The White House Conference can, *and should*, be a fine opportunity to learn about all facets of the lives of our elder citizens. It should not, and *must not*, be made a springboard for the launching of poorly designed or politically inspired legislation in the name of the aged.

4. The so-called problem of aging has again drawn the lines of battle between the international socializers and those who remain freedom-loving Americans.

Let us not be taken in by the promises of government paternalism, free medical care, or "circuses and bread." Let us steadily work for the needs of our aged at the local and community level.

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**MIGRAINE**

It is generally conceded that several million people in the United States suffer from some type of migraine, making it a subject which interests, or should interest, every practicing physician. The symptoms commonly associated with migraine are: premonitory hyperactivity, irritability, mental depression, emotional unbalance, insomnia, visual disturbances (scintillating scotoma, blurring, diplopia), body aching, fatigue, abnormal appetite, constipation, nausea and vomiting, and often vasomotor disturbances, such as sensations of chilliness.

No one individual will have all these symptoms during one attack of migraine, and, indeed he may never experience all of them, since there is a great deal of individual variation.

Not long ago an article by Dr. Walter C. Alvarez appeared in *Geriatrics* (14:433-442, 1959) entitled, "The Many Causes of Migraine in Middle-Aged and Elderly Women." The author outlined three main causes of migraine: (1) An hereditary predisposition, (2) A sensitizing factor that cocks a trigger in the body or brain, and sets it free and (3) A set of triggers, any one of which can start an attack in a few minutes.

He mentions a multitude of causes: mental overwork, resentments and antagonisms, worry, boredom, acute tension, too much responsibility,

allergy, overeating, fright and fears, anger, noise, excitement, vasodilator drugs, eyestrain, constipation, excessive smoking, an approaching rainstorm (barometric changes), and still others. The author also cites as a cause any happening out of the ordinary, such as travel, sight seeing, a late breakfast, hurrying or being hurried, anticipation (as a son arriving on a train), dread of some happening or task, looking at bright or flashing lights on certain designs, unaccustomed energetic exercise or sleeping late.

It is obvious that there are variegated causes. It would almost seem that practically anything could precipitate an attack of migraine. This is probably true in those who are highly susceptible. Undoubtedly a psychic component plays an important part in many individuals.

It is known also that certain articles in the diet are prone to bring on migraine. Chocolate is supposed to be one of the greatest offenders. Nuts and milk, too, may precipitate an attack in certain individuals. There are doubtless other food products which may affect certain people.

It is patently impossible for a person suffering from migraine to avoid all things which may produce an attack. In order to do so he would have to go into seclusion. The best he can do is to make every effort to maintain good physical and mental health. As people become older, migraine attacks, as a rule, are less severe and appear less often, although there are some individuals troubled with migraine when well advanced in years.

Fortunately, certain ergot preparations, especially those which are combined with caffeine, help many sufferers, particularly if they are taken at the onset of the attack. Students of the subject feel that about 80 per cent of migrainous people are greatly aided by this medication. Those not aided by ergot and caffeine must rely upon sedative drugs, or those which allay pain, such as codeine. Sufferers from migraine are often people above average intelligence, many are extremely conscientious and cooperative individuals, and often have a warmth of personality. They deserve all the help the physician can extend them.

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**DRUGS IN AGING**

Drugs, and especially their cost, are coming in for much discussion all the way from the Senate Chamber to the corner drugstore. A recent issue of *The Newsletter of The Gerontological Society* presents an editorial from the pen of Dr. Chauncey D. Leake, Dean of the Ohio State University Medical School, and one of the world's outstanding pharmacologists, under the headline we use above. Doctor Leake is not only a master of pharmacology but of English as well. His editorial is so well presented and so apropos that we reproduce it in toto. Says Doctor Leake:

"Drugs in aging are becoming important. There is fear that the cost of new drugs may interfere with their proper use in old people. This fear depends on the insecurity always associated with lack of self-preparation for the inevitability of old age. Maybe we do have to have social aid in providing the drugs that are needed for the proper care of old people.

"On the other hand, let's remember that drugs can only make living cells do more or less what they are already capable of doing. Let's not fool ourselves into thinking that we can get drugs that will keep us alive indefinitely. We each of us have a responsibility to prepare ourselves for old age and death with equanimity and good humor. Drugs may help. They can be used successfully to relieve pain. They can alleviate the unpleasant symptoms of many diseases. They can help in the preventing of disease. They can promote resistance to diseases. But perhaps fortunately they cannot prolong life indefinitely.

"Characteristic of aging is the need for more vitamins. This requires balancing of vitamins. The same proposition holds for the essential hormones, particularly those dependent upon anterior pituitary stimulation. On the other hand, older people show a decrease in the intensity of histamine action and thus a decrease in the tendency to allergy.

"All the basic principles of pharmacology are pertinent in connection with the use of drugs in older people. One should always remember that there is a tendency toward reduced renal function with age, thus suggesting caution in giving drugs excreted by the kidney so as to avoid cumulative toxicity. Alcohol, the digitaloid drugs, and morphine compounds are more toxic for older people than for younger ones. Similarly, older people do not tolerate sulfa drugs as easily as younger people. Older people are also more sensitive to purgatives.

"There is of course much chance for exaggerated claims of drugs for prolonging youthfulness. The Bogomoletz anticytotoxic serum has little to support its claims for usefulness against aging, and the same comments apply to Aslan's buffered procaine injections.

"We need to develop specific kinds of drugs for use in old age, such as (1) those that may be used to handle cancer; (2) those that may alleviate the symptoms of cardiovascular renal

disease; (3) those that will improve greater protective action from connective tissues; (4) those which may maintain functional activity of the gastro-enteric tract; and (5) those which may help maintain functional enzyme systems so as to keep metabolic processes in satisfactory condition. Fortunately, we may have many useful and safe tranquilizing agents and also drugs that can help in causing some degree of increased brain activity and zest for living. This is all for the good.

"Certainly every effort should be made to support the study of new drugs in aging. This means encouragement to the pharmaceutical manufacturers to use funds for the effective development of new and worth-while drugs. We all need to work together to help get those kinds of chemicals that may aid in handling the increasingly heavy load of medical problems associated with aging."

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**THANKS—AND SUPPORT—DUE BLUE SHIELD**

Like a somewhat wayward child, Blue Shield often plays the role of favorite whipping boy for the doctors who created it. Wherever several physicians are gathered together, in staff room, committee meeting or on the second tee, someone is certain to take out after the local Blue Shield Plan.

When the definitive history of prepayment is written, perhaps one may trace a falling rate of divorce among American physicians who have worked out so many of their frustrations, not on their wives, but on their Blue Shield Plans.

Some Blue Shield administrators confess to a wry satisfaction in all this, recognizing that a parent is always fussier with his own offspring than with a child for whom he has no emotional affinity.

Blue Shield is a vast community umbrella designed to ward off the rain of medical adversity which falleth alike upon the just and the unjust. It serves the need of the average man as best it may, but it sometimes falls a little short of the special needs or wishes of the individual patient and his doctor.

In these perilous times, when the Forand philosophy seems to have so thoroughly infected the politicians of both parties, American medicine has reasons more apparent than ever before to honor those medical pioneers who built Blue Shield, and to support the civic and professional leaders who today are working so hard to make Blue Shield an ever more effective instrument.

None can doubt that without the reality of a strong and growing Blue Shield movement during the 1950's, America would long since have had universal compulsory health insurance. And few today would dispute the proposition that if American medicine escapes the thralldom of state medicine during the 60's, it will have the voluntary prepayment movement, chiefly Blue Shield, to thank for its good fortune.

Let's all keep a closer eye on Blue Shield, not merely to discern the motes in its eye, but to encourage it to do the best job it can do for us and for the American people.

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**NEW MEMBERS**

Elsewhere in this issue there appears for the first time an article listing the new members of the West Virginia State Medical Association. Hereafter, as a new member returns his biographical information card to the headquarters offices he will be introduced to his colleagues by the use of a news note in *The Journal.*

It will be noted that in each instance the biographical sketch is brief, listing only the name, address, county society, birthplace, medical education, internship, residency training and former location. Mention is also made of the type of practice, whether it be a specialty or general practice.

We feel that our readers statewide will be interested in becoming acquainted with the background of our new members. Likewise, we hope that this particular feature will be of some benefit to new physicians locating for practice in various sections of the state.

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### A Cure for Apathy

One of the greatest problems facing this Nation today is the apathy among its people—a lack of interest or participation in community life or public affairs. There is too much of the spirit of "let George do it" and then of not being satisfied with what "George" has done. This apathy is growing to the proportions of a community disease. "Physician heal thyself." Cure your own apathy and accept the position of leadership your public expects of you, and then we can cure the apathy of the rest of the people.

Elections of our government officers at all levels are soon to occur. If we are to preserve our individual freedom and democracy, a majority of the citizens must go to the polls and that majority must be informed and thinking, freedom-loving Americans. If we are to preserve our freedom way of life, we must preserve our democratic laws. To do so we must begin, not where the laws are made, but where the lawmakers are made. We must start in the precinct in each individual polling place.—Ralph W. Jack, M. D., in Journal, Florida Medical Association.

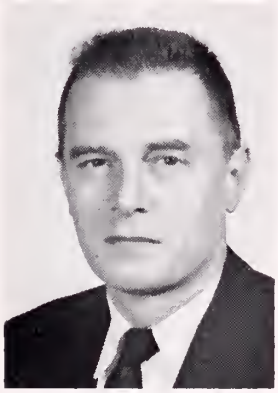
# GENERAL NEWS

## Pyelonephritis Symposium Arranged For Annual Meeting in August

A "Symposium on Pyelonephritis" has been arranged for the first general scientific session during the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

Dr. Seigle W. Parks of Fairmont, chairman of the Program Committee, has announced that three prominent physicians and surgeons will appear as guest speakers at this session which will be held on Thursday morning, August 25. The participants will be as follows:

J. B. Hazard, M. D.



George A. Wolf, Jr. M. D.

Thomas A. Stamey, M. D., Assistant Professor of Urology, Brady Urological Institute of The Johns Hopkins Hospital, Baltimore, Maryland.

John B. Hazard, M. D., Chairman of the Division of Pathology and Head of the Department, Cleveland Clinic Foundation, Cleveland, Ohio.

George A. Wolf, Jr., M. D., Dean and Professor of Clinical Medicine, University of Vermont College of Medicine, Burlington, Vermont.

Doctor Parks said each speaker will present a paper on the various aspects of pyelonephritis, after which there will be a panel discussion with a question and answer period. The speakers will also be asked to discuss several case presentations with protocols which will be mimeographed and distributed at the beginning of the session.

It was announced previously that the first speaker on the Thursday morning program, following brief addresses of welcome, will be Dr. Charles B. Jolliffe, Vice President and Technical Director of the Radio Corporation of America.

### Saturday Morning Program Completed

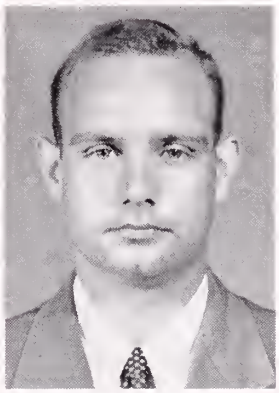
The Program Committee announced that Dr. Vincent J. Collins, prominent anesthesiologist of New York City, has accepted an invitation to present a paper at the third and final general scientific session on Saturday morning, August 27.

Doctor Collins, who is Associate Professor of Anesthesiology at New York University Medical Center, will appear on the same program with Dr. Edward M. Litin, Consultant, Section of Psychiatry, Mayo Clinic, Rochester, Minnesota, and Dr. Roger B. Scott, Associate Professor of Obstetrics and Gynecology, Western Reserve University School of Medicine, Cleveland, Ohio.

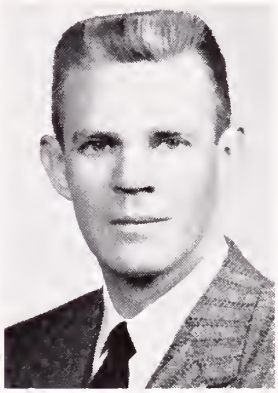
### WVU Program on Friday Morning

The second general scientific session on Friday morning, August 26, will be devoted exclusively to addresses by members of the faculty of the new four-year School of Medicine at West Virginia University.

Among the speakers will be President Elvis J. Stahr, Jr., and Dr. Kenneth E. Penrod, Vice President-Medical Affairs. The Program Committee also expects to arrange for the presentation of papers by various department heads of the School.



Thomas A. Stamey, M. D.



Vincent J. Collins, M. D.

### Section Meetings

Several of the guest speakers will also appear on programs being arranged by the Association's sections and affiliated societies and associations which will be held afternoons during the three-day meeting.

### Two Sessions of House of Delegates

There will be two sessions of the House of Delegates during the annual meeting. Dr. J. C. Huffman of Buckhannon, President of the West Virginia State Medical Association, will present his presidential ad-

dress at the first session at 9 o'clock on Wednesday evening, August 24.

The second and final session will be convened at 3:30 o'clock on Saturday afternoon, August 27, at which time an address will be delivered by Dr. E. Vincent Askey of Los Angeles, California, who will be installed as president of the American Medical Association at the annual meeting in Miami Beach this month.

### Dance on Friday Night

The Woman's Auxiliary, which will hold its 36th annual meeting at The Greenbrier concurrently with the meeting of the State Medical Association, will be in charge of entertainment for the three-day meeting.

A dance with special entertainment will be held in the Main Ballroom of the hotel on Friday evening, August 26, with music by the Meyer Davis Orchestra of The Greenbrier.

### Reception on Saturday Evening

There will be a Cocktail Party and Reception honoring the officers of the West Virginia State Medical Association on Saturday evening, August 27. All members of the Association and Auxiliary, their families, representatives of the industrial exhibitors and guests are invited to attend.

## Dr. Robert P. Hagerman Named Head Of Mental Health Department

Dr. Robert Paul Hagerman, Superintendent of Weston State Hospital, has been named by Governor Cecil H. Underwood as Director of The Department of Mental Health to succeed Dr. Richard J. Lilly, who is now engaged in the private practice of psychiatry at Parkersburg.

Doctor Hagerman is a native of Marshall County. He received his early education in the public schools and had his pre-medical training at West Virginia University. He received his M. D. degree from the University of Maryland in 1923.

Doctor Hagerman served in the United States Army, 1917-19, and with the USPHS, 1923-28. He engaged in private practice at Cameron, 1923-31, at which time he returned to the USPHS to serve as chief medical officer to correctional institutions, a post he held until 1940.

He was with the United States Department of Justice from 1940 to 1957, serving as superintendent of institutions at Denver; Ashland, Kentucky; Chillicothe, Ohio, federal reformatory; the Medical Center at Springfield, Missouri; and Petersburg, Virginia. He retired in 1957.

Doctor Hagerman was chief medical officer for the State Institution at Avon Park, Florida, until April 1959, when he accepted appointment as superintendent of Weston State Hospital.

## Dr. J. B. Nichols, Jr., Certified

Dr. James B. Nichols, Jr. of Charleston, who is associated in the practice of neurological surgery with Dr. C. M. Caudill in that city, has been certified by the American Board of Neurological Surgery.

## Relocations

Dr. Jean Faint Van Sandt of Charleston has moved to Olney, Illinois, where she will continue the practice of ophthalmology with offices at 315 South Jefferson Street.

* * * *

Dr. Joseph H. Nodurft of Wheeling has moved to Marrero, Louisiana, where he will serve as Director of the Department of Anesthesia at the West Jefferson General Hospital. This 160-bed hospital has just been completed at a location across the Mississippi River from New Orleans, just off the West Bank Expressway.

* * * *

Dr. Michael J. Russo of Huntington has moved to Champaign, Illinois, where he will continue the practice of his specialty of surgery. His address there is 606 Hamilton Drive.

## The Skeet and Trap Shooting Tournament

Dr. T. P. Mantz of Charleston has been named chairman of the Skeet and Trap Shooting Tournament which will be held in connection with the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27. The appointment was announced by the president, Dr. J. C. Huffman of Buckhannon.

The other members of the committee are Drs. J. L. Patterson of Logan and Albert C. Esposito of Huntington.

All physicians who are interested in participating in the tournament are requested to communicate with Doctor Mantz so that advance arrangements may be made with the management of the hotel. The address of Doctor Mantz is 601 Atlas Building, Charleston 1, West Virginia.

## Medical Meetings, 1960

The following is a partial list of national, state and district medical meetings scheduled for 1960:

June 11-12—Am. Diabetes Assn., Miami Beach.
June 13-17—AMA Annual Meeting, Miami Beach, Fla.
June 16—11th Annual B-R-T PG Session, Elkins.
June 23—6th Annual Summer Session, Preston Co. Med. Soc., Kingwood.
July 11-13—Medical Licensing Board, Charleston.
**Aug. 25-27—93rd Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.**
Sept. 13-15—National Cancer Conf., Minneapolis.
Sept. 16—W. Va. Heart. Assn., Parkersburg.
Sept. 22-24—W. Va. Hospital Assn., White Sul. Springs.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 9-14—Am. Acad. Oph. and Otol., Chicago.
Oct. 10-14—ACS, San Francisco.
Oct. 17-20—Am. Acad. Pediatrics, Chicago.
Oct. 21-23—PG Institute, Martinsburg.
Oct. 21-25—Am. Heart Assn., St. Louis.
Oct. 31-Nov. 3—Southern Medical, St. Louis.
Nov. 29-Dec. 2—AMA Clinical Meeting, Washington, D. C.

## Mingo County Student Selected For Scholarship Award

Harry Glenn Buchanan of Gilbert, Mingo County, has been selected by the Medical Scholarships Committee of the West Virginia State Medical Association as the 1960 recipient of the four-year scholarship award to the West Virginia University School of Medicine.

Harry Glenn Buchanan

The scholarship, worth $4,000, is awarded annually to a student enrolled in the first-year class at the School of Medicine. The award will be presented formally during the 93rd Annual Meeting of the State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

Announcement of the award was made by Dr. Carl B. Hall of Charleston, the chairman, following a meeting of the committee in Charleston on May 7. Other members of the committee are Drs. Martha J. Coyner, Harrisville, Sobisca S. Hall, Clarksburg, Thomas L. Harris, Parkersburg, Thomas J. Holbrook, Huntington, Russel Kessel, Charleston, J. P. McMullen, Wellsburg, L. E. Neal, Clarksburg, Maynard P. Pride, Morgantown, and Pat A. Tuckwiller, Charleston.

Mr. Buchanan, 21-year-old son of Mr. and Mrs. Arthur B. Buchanan, is a graduate of Gilbert High School. He had his pre-medical training at Berea College in Kentucky and will begin his studies in September as a freshman in the WVU School of Medicine.

Mr. Buchanan is the third student to receive a scholarship under the program inaugurated by the State Medical Association in 1958. The first recipient was Larry Hemmings of Charleston, who will be a third-year student this fall. Last year's winner was Terry T. Tallman of Alma, Tyler County, who has completed his first year at the School of Medicine.

### Auxiliary Conference in Charleston

A Regional Conference of the Woman's Auxiliary to the West Virginia State Medical Association was held at the home of Dr. and Mrs. Pat A. Tuckwiller in Charleston on April 27.

Mrs. Tuckwiller, fourth vice president of the State Auxiliary, presided at the meeting which was attended by officers and committee chairmen of component auxiliaries from the Southern Region of West Virginia.

Other state officers appearing on the program were Mrs. Clark K. Sleeth of Morgantown, president elect; Mrs. A. C. Chandler of Charleston, program chairman; and Mrs. W. A. Thornhill, Jr., of Charleston, revisions chairman.

## Dr. Perry S. MacNeal To Speak At Meeting in Kingwood

The 6th Annual all day summer meeting of the Preston County Medical Society will be held at the Preston Country Club near Kingwood on Thursday, June 23. The day will be devoted to sports, including fishing, archery and golf and trap shooting tournaments.

The banquet will be served at 7 o'clock, following a social hour in the club house. The guest speaker will be Dr. Perry S. MacNeal of Philadelphia, Associate Professor of Clinical Medicine at the University of Pennsylvania School of Medicine.

Dr. John W. Trenton of Kingwood is general chairman of the meeting. All physicians who expect to attend are requested to notify Dr. C. Y. Moser, Secretary of the Preston County Medical Society, Kingwood, prior to June 16.

Harry Glenn Buchanan (extreme left) of Gilbert, Mingo County, recipient of the 1960 four-year medical scholarship awarded by the State Medical Association, is shown with members of the Medical Scholarships Committee during a meeting in Charleston on May 7. Others in the picture are, left to right, Drs. Thomas J. Holbrook of Huntington, J. P. McMullen of Wellsburg, Maynard P. Pride of Morgantown, Martha Jane Coyner of Harrisville, J. C. Huffman of Buckhannon, president of the State Medical Association, and Carl B. Hall of Charleston, chairman of the committee.

## Doctor Pickens Installed as President Of W. Va. Chapter, AAGP

Dr. J. Keith Pickens of Clarksburg was installed as president of the West Virginia Chapter of the American Academy of General Practice during the Eighth Annual Scientific Assembly held at the Daniel Boone Hotel in Charleston, May 6-8.

Doctor Pickens succeeds Dr. Myer Bogarad of Weirton, who will serve as chairman of the Board of Directors during the coming year.

Dr. Randall Connolly of Vienna was named president elect and will assume his duties as president at the annual meeting in 1961. He served as secretary of the organization during the past year.

Other officers were elected as follows:

Dr. Don S. Benson of Moundsville, vice president (reelected); Dr. Liskie J. Moore of Huntington, secretary; and Dr. Joseph A. Smith of Dunbar, treasurer (reelected).

Dr. Seigle W. Parks of Fairmont was reelected to a two-year term as delegate to the annual Scientific Assembly of the American Academy of General Practice. He and Dr. Thomas H. Blake of St. Albans will represent the West Virginia Chapter at the 1961 meeting in Miami Beach, Florida. The alternate delegates are Drs. Halvard Wanger of Shepherdstown and Logan W. Hovis of Parkersburg.

### The New Academy President

Dr. J. Keith Pickens, the new president, has been active in Academy work since its formation and served for several years as chairman of the membership committee.

He is a native of Clarksburg and was graduated from West Virginia University in 1934. He attended the two-year WVU School of Medicine and received his M. D. degree from Northwestern University Medical School in 1939.

He interned at Denver General Hospital in Denver, Colorado, 1940-41, and took postgraduate work in obstetrics and gynecology at the Margaret Hague Maternity Center in Jersey City, New Jersey.

He was licensed in West Virginia in 1941 and engaged in general practice in several communities in the state before locating in Clarksburg in 1948.

Doctor Pickens served as secretary of the Academy for two terms and was named president elect at the annual meeting in 1959.

More than 235 physicians attended the three-day meeting. Dr. Pickens served as general chairman and Dr. Tracy N. Spencer, Jr., of South Charleston, was in charge of local arrangements.

### Address by Doctor Bogarad

Dr. Myer Bogarad presided as speaker at a session of the House of Delegates which was held on Saturday morning. The agenda included reports of committee chairmen, election of officers and an address by Doctor Bogarad.

He called upon physicians to think in terms of the "whole patient" in their concept of medical care. He also cited the importance of postgraduate education for all physicians.

### Scientific Program

The first scientific session was held on Friday afternoon, May 6. The program, devoted to presentation of papers on the subject of cancer, was sponsored by the West Virginia Division of the American Cancer Society. Dr. Hu C. Myers of Philippi served as moderator.

The formal opening of the meeting was held prior to the scientific session on Friday afternoon. The invocation was given by Rev. Robert W. Kirkpatrick of Charleston and addresses of welcome were delivered by Dr. J. C. Huffman of Buckhannon, president of the State Medical Association; Dr. Milton J. Lilly, Jr., of Charleston, president of the Kanawha Medical Society; and Mr. Charles Lively, executive secretary of the West Virginia State Medical Association.

Thirteen prominent physicians and surgeons presented papers at the scientific sessions held during the meeting. Dr. Richard E. Flood of Weirton served as chairman of the Program Committee and the moderators were Drs. John W. Whitlock of Beckley, Clark K. Sleeth of Morgantown, Donald H. Lough of Clarksburg and Jack D. Woodrum of Hinton.

Myer Bogarad, M. D.
Retiring President

J. Keith Pickens, M. D.
New President

Buford W. McNeer, M. D.
Toastmaster

Perry E. Gresham, Ph. D.
Banquet Speaker

### Dr. Perry E. Gresham Banquet Speaker

Perry E. Gresham, Ph.D., president of Bethany College, was the guest speaker at the banquet which was held on Saturday evening. His subject was "Mind, Body and Personality."

Dr. Buford W. McNeer of Hinton served as toastmaster for the banquet, which was preceded by a cocktail party. The past president's pin was presented to Doctor Bogarad by Dr. Seigle W. Parks, a past president of the Academy and editor of *Mister Doc*.

### Entertainment for Wives

Mrs. Tracy N. Spencer, Jr., of South Charleston, was in charge of the entertainment program for wives of physicians. The program included a tour of the Governor's Mansion on Saturday morning and a luncheon and style show at the Charleston Tennis Club at noon.

**Dr. Joseph A. Smith of Dunbar, left, is shown with two of the guest speakers during the annual meeting of the West Virginia Chapter, AAGP, in Charleston, May 6-8. In the center is Dr. Victor G. deWolfe and on his left, Dr. George Crile, Jr., both of whom are members of the staff at the Cleveland Clinic.**

## Dr. G. N. Casto, Jr., Accepts Office In ADA Organization in Chicago

Dr. G. N. Casto, Jr., of Charleston, who has been engaged in the practice of dentistry in Charleston since 1951, has accepted appointment as assistant executive secretary of the American Dental Association. He will have offices at the headquarters in Chicago, and will leave for that city with his family early in June.

Doctor Casto is secretary of the West Virginia Dental Society, and his successor will be named at the annual meeting of that group at The Greenbrier in White Sulphur Springs, July 17-20.

## Noted Epileptologist To Be Honored

Physicians are cordially invited to attend a dinner meeting honoring Dr. William G. Lennox, noted epileptologist of Boston, which will be held at the Harvard Club in that city on June 12. The sponsor of the affair is the American Epilepsy Federation.

Tickets must be reserved and paid for in advance by forwarding a check for $6.50 to "An Evening with Doctor Lennox," Room 204, 73 Tremont Street, Boston 8, Massachusetts.

**Dr. Myer Bogarad, left, retiring president of the West Virginia Chapter, AAGP, receives past president's pin from Dr. Seigle W. Parks of Fairmont during the banquet held in connection with the Eighth Annual Scientific Assembly of the Academy.**

## Regional Meeting of Auxiliary Held in Morgantown, May 4

A regional meeting of the Woman's Auxiliary to the West Virginia State Medical Association was held at the West Virginia University Medical Center in Morgantown on May 4. Representatives and guests from nine county auxiliaries in the Eastern and North-Central regions attended the meeting.

Mrs. Vernon L. Dyer of Petersburg, Director of the Eastern Region, presided at the conference which served as a workshop for newly elected auxiliary officers and committee chairmen.

Mrs. Robert R. Pittman of Marlinton, the state president, was among the speakers at the one-day Conference. She said that there are now 23 component auxiliaries within the state organization, with a membership of 1,062. She also said that various auxiliaries had contributed approximately $2,400 to the AMEF.

Reports were presented by the following officers and committee chairmen: Mesdames Earl S. Phillips, Wheeling, John D. Lindsay, Fairmont, Clark K. Sleeth, Morgantown, G. Thomas Evans, Fairmont, Edward J. Van Liere, Morgantown, J. C. Huffman, Buckhannon, L. Dale Simmons, Clarksburg, and Herbert N. Shanes, Grafton.

Members of the Woman's Auxiliary to the Monongalia County Medical Society served as hostesses at a luncheon held following the business session. Mesdames Edward J. Van Liere, Milford Hobbs and Hubert A. Shaffer were in charge of arrangements.

A guided tour of the new Teaching Hospital at the WVU Medical Center concluded the meeting.

## MLB to Meet July 11-13

The regular summer meeting of the Medical Licensing Board will be held at the new State Office Building in Charleston, July 11-13, 1960, for the purpose of examining applicants for licensure to practice in West Virginia.

# Statement of Policies Governing Operation Of WVU Hospital and Clinics

The following statement of policies governing the operation of the new West Virginia University Hospital and Clinics has been approved by the Board of Governors:

"The primary objectives of the West Virginia University Medical Center are to provide training to students in the multiple disciplines of the health fields and to extend the boundaries of knowledge in the sciences and arts dealing with human health and illness. The pursuit of these objectives requires the provision of patient care of the highest quality and of the maximum possible variety. These factors determine the operational policies set forth herewith.

"Patients will be admitted upon referral by a physician and upon discharge will be returned to the referring physician for continuing care. No patient will be refused attention and admission in the event of need for emergency care.

"The costs of care provided at the Medical Center will be the responsibility of the patient unless the care has been authorized by an agency or 'third party.'

"Any patient admitted to the University Hospital and Clinics may be used in the teaching program without regard to individual ability to pay for care. The Medical Staff of the University Center will have the right to accept or reject patients to meet the demands of teaching needs.

"The following categories of patients are established:

"1. *Private patients* are patients referred either to a department of the Medical School and assigned to a member of the department or referred directly to a particular member of the staff. Such patients pay private clinic fees, hospital fees and physicians' fees. They will be limited in number and will be used in the teaching program as are all patients of the University Hospital.

"2. *Pay patients* are patients referred to the University Hospital and Clinics. Assignment to a department will be the responsibility of the staff after appropriate evaluation. They will pay at least clinic and hospital costs. It is anticipated that the majority of patients will be of this category.

"3. *Part-pay patients* are clients of certain agencies or beneficiaries of various programs which do not pay full costs of care but with which contractual arrangements have been made by the Hospital and Clinics.

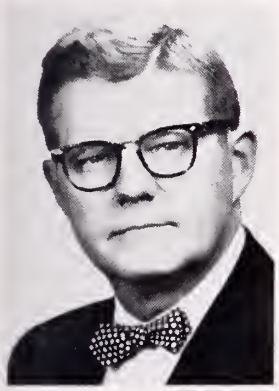
"4. *Special teaching and research patients.* A limited number of patients may be admitted for teaching purposes only. That is, their condition may not require hospital or clinic care, but because of teaching value they are admitted and have the costs of their care borne by the Medical Center."

Officials of the Medical Center in Morgantown have stated that in all probability the hospital clinics will be opened on August 1, and that the hospital itself will be fully equipped, staffed and ready for opening not later than September 1.

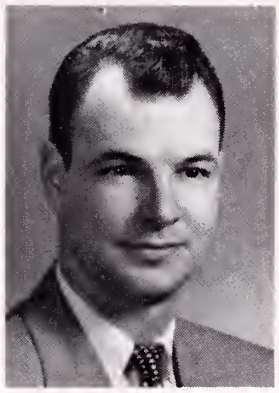
## New Staff Appointments Announced By WVU School of Medicine

The appointment of two new staff members to the Department of Surgery at the West Virginia University School of Medicine was announced recently by President Elvis J. Stahr, Jr.

Dr. Herbert E. Warden of Minneapolis, Minnesota, has been named Associate Professor of Surgery and he will join the faculty on July 1. He is the first appointee to the staff of Dr. Bernard Zimmermann, who recently was named Professor of Surgery.



Herbert E. Warden, M. D.



Walter H. Moran, Jr., M. D.

Doctor Warden, recognized as an authority in the field of heart surgery and as a research scientist, is currently serving as instructor in surgery and staff surgeon at the University of Minnesota Hospitals and assistant thoracic surgery consultant at Anoka State Hospital.

He is a native of Cleveland, Ohio, and was graduated from Washington and Jefferson College. He received his M. D. degree from the University of Chicago School of Medicine, and his Ph. D. from the University of Minnesota.

Doctor Warden served his internship at the University of Chicago Clinics and then served for two years with the Medical Corps of the United States Marines. He joined the staff at Minnesota in 1951.

He received the Albert Lasker Award for Medical Research from the American Public Health Association in 1955. He also received AMA Certificates of Merit for scientific exhibits on open heart surgery in 1955 and 1957. He was the recipient of the Hekteon Gold Medal in 1957.

Commenting on the appointment, Doctor Zimmermann said: "This is the man I wanted to build a department around. Not only is he a well-trained and skilled general surgeon, but he has had extensive experience in all forms of thoracic surgery, including as much open heart work as anyone in the world. And, most important, he is an excellent and dedicated teacher."

The other appointment announced was that of Dr. Walter H. Moran, Jr., also of Minneapolis, as Senior Resident and Instructor in Surgery. He was also named to head the surgical laboratories at the Medical Center.

Doctor Moran was born in Grand Forks, North Dakota and graduated from the University of North Dakota in 1952. He received his M. D. degree from Harvard Medical School in 1955. He interned at the University of Minnesota Hospitals, 1955-56, and has been serving a residency in surgery there since 1956.

## 11th Annual B-R-T PG Meeting In Elkins, June 16

The 11th Annual Postgraduate meeting of the Barbour-Randolph-Tucker Medical Society will be held at the Elks Country Club near Elkins on Thursday, June 16.

As usual, a golf tournament has been arranged, with play set to start at 9:00 A. M. (EST).

The afternoon program which will be in the nature of a symposium on athletic injuries, will get under way at 2 o'clock, and the following program will be presented:

"Field Injuries."—A. C. Gwynne, Head Athletic Trainer, West Virginia University, Morgantown.

"Selected Athletic Injuries."—Albert Ferguson, M.D., Silver Professor of Orthopedic Surgery and Head of the Department of Orthopedics, University of Pittsburgh.

"Neurological Injuries Associated with Athletics." —Anthony Susen, M. D., Associate Professor of Neurosurgery, University of Pittsburgh.

Dinner will be served at six-thirty. The guest speaker will be Harry Gilmore, backfield coach of the Pittsburgh Steelers, professional football team. He is a former All American from the University of Alabama.

A cordial invitation has been extended by the Barbour-Randolph-Tucker Medical Society to all interested physicians to attend this annual meeting.

### Dr. Mallamo Heads Golf Committee

Dr. Joseph T. Mallamo of Fairmont has been named chairman of the Medical Golf Tournament which will be held in connection with the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27. The appointment was announced by Dr. J. C. Huffman of Buckhannon, president of the Association. The other members of the committee are Drs. Robert S. Wilson of Clarksburg and George A. Curry of Morgantown.

### Film on Control of Hospital Infection

A new film outlining a control program to combat cross infection in a modern hospital has been produced by Winthrop Laboratories and is available for showings at county society meetings.

The 16 mm. color and sound film was produced at the University of Texas Medical School and the John Sealy Hospital in Galveston. Further information may be obtained by writing to Winthrop Laboratories, 1450 Broadway, New York City.

## Rural Health Committee to Conduct Survey of 'Health' Facilities

The State Medical Association's Rural Health Committee has authorized the chairman, Dr. Earl L. Fisher of Gassaway, to conduct a statewide survey concerning medical, hospital and nursing facilities available in the various towns over the state with a population of 700 or over. The action with reference to the survey was taken by the committee at a meeting held in Charleston on May 6.

Doctor Fisher has asked the secretaries of the numerous Lions Clubs over the state to assist in the survey.

The State Medical Association awards a scholarship annually to a member of the freshman class of the School of Medicine of West Virginia University. The selection is made by the Association's Committee on Medical Education and Scholarships, and the recipient agrees, upon the completion of his four years in medical school and internship, to practice for four years in a rural community selected by the committee after consultation with the Committee on Rural Health.

The information obtained by the committee as the result of questionnaires returned by secretaries of Lions Clubs will at the proper time be made available to the Committee on Medical Education and Scholarships.

Besides the chairman, Doctor Fisher, the meeting at Charleston was attended by Drs. Harold D. Almond, Buckhannon; Andrew E. Amick, Lewisburg; J. C. Arnett, Rowlesburg; Martha J. Coyner, Harrisville; V. L. Dyer, Petersburg; M. H. Maxwell, Moorefield; Buford W. McNeer, Hinton; and Charles E. Staats, Charleston.

The meeting was also attended by Dr. J. C. Huffman of Buckhannon, president of the State Medical Association.

## Mrs. Goodhand Guest Speaker At Meeting in Wisconsin

Mrs. Charles L. Goodhand of Parkersburg represented the Woman's Auxiliary to the American Medical Association at the annual meeting of the Auxiliary to the State Medical Society of Wisconsin, which was held in Milwaukee, May 3-5.

Mrs. Goodhand, first vice president of the AMA Auxiliary, delivered an address on "Current Status of Medical Legislation." She also spoke on "Membership" during the three-day meeting.

In addition to her duties as first vice president, Mrs. Goodhand is chairman of the AMA Auxiliary's Membership Committee. She also has served several terms as chairman of the Legislative Committee.

### Auto Emblems Available

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters office in Charleston. The price of each emblem is $3.25 postpaid.

### New Committee on Contact Lens

Dr. Edwin M. Shepherd of Charleston has been named Chairman of a special Committee on Contact Lens of the West Virginia Academy of Ophthalmology and Otolaryngology. The appointment was announced during the annual meeting of that group at The Greenbrier in April by Dr. N. K. Joseph of Wheeling, retiring president of the West Virginia Academy.

Other members of the Committee are as follows: Drs. Ralph W. Ryan of Morgantown, R. Alan Fawcett of Wheeling, and Albert C. Esposito of Huntington.

The 14th Annual Meeting of the Academy will be held at The Greenbrier in White Sulphur Springs, April 6-8, 1961.

Shown at a meeting of the State Medical Association's Rural Health Committee in Charleston on May 6 are, left to right, Drs. J. C. Huffman, president of the Association, Charles E. Staats of Charleston, J. C. Arnett of Rowlesburg, Earl L. Fisher of Gassaway, chairman of the committee, Harold D. Almond of Buckhannon, Andrew E. Amick of Lewisburg, Buford W. McNeer of Hinton, Vernon L. Dyer of Petersburg, M. H. Maxwell of Moorefield, and Martha Jane Coyner of Harrisville.

## Dr. Morris Fishbein Guest Speaker Before Ohio County Society

Dr. Morris Fishbein, former editor of the *Journal of the American Medical Association*, was the guest speaker at the banquet held in connection with the meeting of the Ohio County Medical Society at Wilson Lodge, Oglebay Park, Wheeling, on April 26. His subject was "Fifty Years of Medical Progress."

The speaker said that the medical profession and the public must combine their abilities to attract talented and better qualified medical students. He pointed out that, while six years ago there were six applicants for every vacancy in a medical school, the number has now dropped to two for every opening.

He declared that "anything less than the best in medical education is not good enough." He insisted that there is need for more medical schools, with qualified personnel to serve as members of the faculty.

"If medicine is to continue to conquer the mysteries of disease as it has in the past," he said, "it must attract the greatest minds in the nation to maintain the progress."

### New Officers Elected

At the business session following the scientific program, Dr. S. S. Bobes of Wheeling was installed as president of the Society.

Other officers were named as follows: President, Dr. W. J. Steger; vice president, Dr. A. L. Wanner; secretary, Dr. H. G. Dickie, Jr.; and treasurer, Dr. D. W. Palmer.

The retiring president, Dr. L. A. Lyon, presided at the meeting, and the guest speaker was introduced by Dr. J. C. Huffman of Buckhannon, President of the West Virginia State Medical Association.

More than 100 physicians attended the banquet which was preceded by a cocktail party for members and guests.

**Harley B. Reger of Clarksburg, rehabilitation counselor for the Division of Vocational Rehabilitation, was the guest speaker at a meeting of the Central West Virginia Medical Society in Weston on April 28. Left to right, Dr. John E. Echols of Richwood, the president, Dr. Jane Freeman of Buckhannon, secretary, Mr. Reger, and Dr. J. M. Cofer of Bergoo.**

## New Film on Cancer Detection

"The Cancer Detection Examination" is the title of a new film which is available for showings at county society meetings. The film was produced by Eli Lilly and Company from a video tape of a closed-circuit telecast in cooperation with the American Cancer Society, New Jersey Division.

Dr. Emerson Day of New York City is the moderator and he demonstrates the presymptomatic detection of cancer through simple office procedures. The black-and-white 16 mm. film requires a showing time of 46 minutes.

Further information may be obtained by writing to Eli Lilly and Company, P. O. Box 814, Indianapolis 6, Indiana.

**Dr. Morris Fishbein of Chicago (third from left) was the guest speaker at a meeting of the Ohio County Medical Society which was held in Wheeling on April 26. Other physicians shown in the photo are, left to right, Dr. Robert J. Reed, Jr., a past president of the State Medical Association; Dr. D. E. Greenelteh, vice president of the Association; Dr. L. A. Lyon, immediate past president of the Society; Dr. J. P. McMullen, a past president of the Association; and Dr. J. C. Huffman, president of the Association.**

## The Practice of Medicine As Seen by a Newsman

*Ed.: Reprinted below is an editorial which appeared recently in the Fort Lauderdale (Florida) News. The author is Harvey Call.*

It has been nearly a decade since the American Medical Association was roused out of its lethargy to fight the threat of socialized medicine in this country. Outright alarm on the part of the professionals prompted them to wage an all-out public relations program to bat down encroachment in their field.

Doctors were warned in stern tones by their organizations that their own actions were a threat to their future. Medical men were urged to abandon their Cadillacs for less showy and less costly transportation. They were called upon to show consideration to their patients and give better service.

*See Editorial on Page 207*

Through these and other maneuvers, the threat of socialized medicine subsided and things lapsed into a more normal pattern. During the years that have intervened, some in the professional ranks have forgotten the hard-learned lessons of the early 1950s. Old practices, old problems for the patients have crept back into being.

And today efforts are being made to inch socialized medicine into our way of life. Up for consideration in Congress is the Forand Bill [H.R. 4700] which would provide hospital-surgical and nursing home care for the aged as a related item of the Social Security program.

The idea has tremendous appeal to millions of senior citizens who fear that illness and its exorbitant costs will deplete their meager savings. Driving hard for the measure, too, are the AFL-CIO forces interested basically in a complete socialized medicine program. For 14.3 million Social Security beneficiaries eligible to participate, the program would provide just that—socialized medicine.

They would be entitled to 120 days of combined hospital and nursing home care in any 12-month period, including bed and board in a semi-private room, nursing, laboratory and ambulance services, drugs and appliances, the use of operating room and staff services.

All of this would be paid for through an added levy of the Social Security program. Buttering up the program are several arguments that are winning support for the Forand measure. It would assure the aged of health care, one of their greatest needs. The promise of higher quality services are held out through government supervised and regulated programs.

This digs into one of the greatest problems facing the medical profession in its fight to defeat the program. There is wide-spread concern and dissatisfaction with the costs and quality of medical care today. Medical and hospital charges have risen steadily over the years

**Dr. J. C. Huffman of Buckhannon, president of the West Virginia State Medical Association, was an honor guest at the Spring Meeting of the State Executive Board of the Woman's Auxiliary which was held in Weirton, April 19-20. Others in picture are, left to right (seated), Mrs. V. L. Dyer of Petersburg, first vice president; Mrs. R. R. Pittman of Marlinton, president; and Mrs. Myer Bogarad of Weirton, second vice president. Standing, Mrs. J. Preston Lilly of Charleston, parliamentarian; Mrs. Pat A. Tuckwiller of Charleston, fourth vice president; Mrs. James W. Hamilton of Marlinton, corresponding secretary; and Mrs. George Rigas, president of the Hancock County Auxiliary. (Photo courtesy of the Weirton Daily Times).**

and are at the point today where any major illness constitutes an acute financial strain on the family and the individual.

Illness involving an operation can wipe out years of savings in a few weeks. Drug costs are high. Nursing costs tax family budgets to the breaking limits.

Doctors readily defend the increases as in line or under the price jumps in related fields of living. That, however, makes the burden no easier for those afflicted. With the public generally, there is not too much sympathy for the doctors' cause because of numerous factors, many of them irritations occasioned by the profession itself. Among these is the changed concept of the medical man. Where the doctor was looked upon at one time as the good Samaritan ready with his satchel at all times to heal and comfort the wounded and the sick, he has become a businessman today.

The doctor maintains fairly rigid office hours, charges a sizable fee for a few minutes of his time and may be difficult or impossible to reach in time of need after hours. Medical groups have established round-the-clock standbys of doctors who may be on call. That, nevertheless, is a far cry from the comfortable, personal relationship that once existed between patient and doctors. In time of pain, the familiar face was reassuring and comforting in itself. (*Ed.: It still is*).

A patient able to find a doctor when needed is quite apt today to see hovering over him a stranger—giving rise immediately to concern as to whether this new fellow really knows what he is doing. This certainly is a convenient plan for the doctors, but it has forced the patient into exactly the big weakness of socialized medicine—the fact the patient generally has to accept whatever services and skills the socialized program makes available.

For that reason, the medical profession is pushing the public pell mell down the highway towards socialized medicine. Even if it should succeed sidetracking the Forand program, the present course is bringing the big change closer every day.

## New Association Members

Dr. Bill Robert Blackburn, The Golden Clinic, Elkins (Barbour-Randolph-Tucker). Doctor Blackburn, a native of Denison, Texas, received his M. D. degree in 1946 from Baylor University College of Medicine. He interned at Baroness Erlanger Hospital in Chattanooga, Tennessee, and served residencies at that hospital and at the Veterans Administration Hospital in Houston, Texas. He formerly practiced his specialty of surgery in Houston.

* * * *

Dr. Edith Cserny, Acting Superintendent, Huntington State Hospital (Cabell). Doctor Cserny was born in Arad, Hungary, and received her medical training at the Medical School of the University of Cuij in Romania. She served her internship and had residency training at hospitals in Arad. She was licensed to practice in West Virginia in 1957. Her specialty is psychiatry.

* * * *

Dr. Hans Werner Dransfeld, 6 Taylor Road, Huntington (Cabell). Doctor Dransfeld was born in Hagen, Germany, and received his medical education at Philipps University in Marburg, in that country. He served his internship and had residency training at St. Mary's Hospital in Huntington, 1953-58. His specialty is radiology.

* * * *

Dr. Gary L. Ripley, 2029 Enslow Boulevard (Cabell). Doctor Ripley was born in New Philadelphia, Ohio, and received his M. D. degree from the Medical College of Virginia in 1956. He interned at Mercy Hospital in Springfield, Ohio, 1956-57, and then served in the Medical Corps of the Army, being assigned to the United States Army Hospital at Camp Walters, Texas. He is now engaged in general practice.

* * * *

Dr. Carl J. Greever, Whitesville (Boone). Doctor Greever is a native of Bluefield. He received his M. D. degree from the Medical College of Virginia in 1958, and interned at Kings County Hospital in Brooklyn. He is engaged in general practice.

**A meeting of the Publication Committee of the West Virginia State Medical Association was held at the Daniel Boone Hotel in Charleston on May 8. Left to right, Drs. Edward J. Van Liere of Morgantown, R. H. Edwards of Welch, Walter E. Vest of Huntington, the editor, E. Lyle Gage of Bluefield, and George F. Evans of Clarksburg. Drs. W. M. Sheppe and William L. Cooke of Charleston were absent when the picture was taken.**

## Dean Van Liere Honored at Meeting In Morgantown, May 12

High honors were paid Dr. Edward J. Van Liere, Dean of the West Virginia University School of Medicine, at a special program at the Medical Center in Morgantown on May 12.

Doctor Van Liere, who has served as dean for the past 25 years, will retire on June 30.

Dr. Thomas L. Harris of Parkersburg, President of the University Board of Governors, presided at the meeting which was held in the auditorium in the School of Medicine. Dr. C. J. Wiggers, Professor Emeritus at Western Reserve University, who was introduced by Dr. Fred R. Whittlesey of Morgantown, a former pupil, presented a paper on the subject of "Modern Concepts of Hemodynamic Effects of Aortic Insufficiency."

The second paper was presented by Dr. D. B. Dill, Scientific Director of Medical Research, Chemical Warfare Laboratories, Army Medical Center in Maryland. His subject was "Rescue Breathing." He was introduced by Dr. Kenneth E. Penrod, Vice President-Medical Affairs, WVU School of Medicine.

### Student Loan Fund Contributions Reported

Dr. John W. Hash of Charleston, President of the Alumni Association of the School of Medicine and President Elect of the State Medical Association, was introduced by Doctor Harris and made a special presentation of a check for $2,100 from Kanawha Medical Society for the student loan fund created in honor of Doctor Van Liere. The official name of the fund is the E. J. Van Liere Medical Student Loan Fund.

In addition to the contribution from Kanawha Medical Society, Doctor Hash announced a gift of $887 from the Alumni Association of the School of Medicine which increases the total amount now in the fund to an even $10,000.

This revolving loan fund is operated by the West Virginia Foundation for the benefit of students in the Medical School. All loans made to students are repaid to the Foundation and kept in the general fund.

### Dean's Portrait Formally Accepted

Dr. Carl E. Johnson of Morgantown presented to the University a portrait of Dean Van Liere, which was accepted by President E. J. Stahr, Jr.

A reception in honor of Dr. and Mrs. Van Liere was held in the Faculty Lounge immediately following the program.

Doctor Van Liere will, upon his retirement from the office of dean, continue to serve as professor of physiology at the Medical School.

## W. Va. Heart Association To Meet In Parkersburg, Sept. 16

The Annual Meeting of the West Virginia Heart Association will be held at the Chancellor Hotel in Parkersburg on September 16. Dr. J. J. Jenkins of Fairmont is president of the Association, having been elected at the Annual Meeting at Martinsburg last September. Dr. A. C. Woofter of Parkersburg will be installed as the new president at the meeting in Parkersburg.

Dr. Morris H. O'Dell of Charleston and Dr. James H. Walker, also of that city, are currently serving as Vice President and Secretary, respectively. Frederick S. Kelley of Charleston is the executive director, and Mr. R. E. Plott, also of that city, is treasurer.

## Three Aspects of Old Age

Three aspects of old age of grave concern to the individual are maintenance of income, maintenance of health, and maintenance of social adjustment. If any of these factors are woefully deficient, the chances of growing old gracefully are poor.—E. S. Weaver, M. D., in Journal, Kentucky State Medical Association.

Shown above are the West Virginia residents who participated in the first Public Health Service Training Course in Health Mobilization at Brooklyn, New York, April 18-23. Front row, left to right, Dr. George Moore, Chief of Health Mobilization Service, Public Health Service Region III, Samuel J. Hawkins, Charleston, Dr. N. Allen Dyer and Dr. John J. Mahood, Bluefield, Miss Ruth B. Melber, Miss Mary Coyer and Dr. L. A. Dickerson, Charleston. Standing, A. Lynn Keyser and Dr. John A. B. Holt, Charleston, Dr. Ralph W. Ryan, Morgantown. Dr. Robert H. Davis, Clarksburg, Dr. David M. Wayne, Bluefield, Dr. Robert B. Davis, Clarksburg, and Dr. Harlan A. Stiles, Huntington. Dr. E. E. Hutton, Jr., of Elkins, was absent when the picture was taken.

The West Virginia Medical Journal

July, 1960 Vol. 56, No. 7

# Multiple Malignant Primary Neoplasms*

## (Case Report)

*James E. Boggs, M. D., John T. Jarrett, M. D., and John E. Lutz, M. D.*

The occurrence of multiple malignant tumors is unusual, with the exception of polyposis of the colon and of epidermal tumors of the skin. The patient in the case reported in this paper apparently has survived three distinct primary malignant tumors of major importance. They are (1) adenocarcinoma of right colon (1948), (2) adenocarcinoma of jejunum (1950) and (3) adenocarcinoma of uterus (1951). There is no evidence of recurrence nor of residual disease after a period of almost nine years.

A review of the American literature disclosed only a few articles concerning multiple malignant primary neoplasms, and most of these are published series of autopsy data. One of the first reports dealing with the living patient primarily was published by Hurt and Broders, of the Mayo Clinic, in 1933.[1] In their series of 2,124 cases of malignant tumors, there were 71 in which there were multiple primary malignant tumors, an incidence of 3.3 per cent. One of the next extensive reviews of the subject was published by Stalker[2] and others, of the University of Minnesota, in 1939. Their series consisted of 2,500 cases of malignant tumors, the incidence of multiple primary malignant tumors being 13.1 per cent. They included, however, epidermal tumors of the skin, which increased the incidence figure.

The most recent review was published by Wallace,[3] of the University College Hospital, London. Wallace discussed 3,006 cases in which the patient had been followed between January, 1946, and December, 1950. Of this number, there were 134 cases in which a total of 299 primary neoplasms had occurred, or an incidence of 4.5 per cent of cases in which there had developed two or more primary neoplasms.

*The Authors*

- James E. Boggs, M. D., Chief Resident in Surgery, Memorial Hospital, Charleston, W. Va.
- John T. Jarrett, M. D., Member of the Surgical Staff, Memorial Hospital, Charleston, W. Va.
- John E. Lutz, M. D., Chief of Surgery, Memorial Hospital, Charleston, W. Va.

### Case Report

The patient, a 35-year-old white woman, was referred to one of the authors in June, 1950, with the diagnosis of possible metastatic carcinoma of the colon. Her complaints were abdominal pain, loss of weight and anorexia. A letter from the referring physician confirmed the fact that the patient had undergone hemicolectomy in May, 1948, at the age of 33 years, for adenocarcinoma of the ascending colon. This was confirmed also by the pathologist, and the slides were reviewed.

Physical examination was within normal limits except for the suggestion of a possible mass in the right upper abdominal quadrant, on palpation.

X-ray studies of the colon, stomach and small bowel were reported as normal, with the exception of absence of the right side of the colon. There was no evidence of anemia.

The patient was seen again, three months later, at which time she complained of pain in the right upper abdominal quadrant, progressive weakness and weight loss. During the three month interval she had lost ten pounds. She appeared chronically ill and extremely pale.

*From the Tumor Clinic, Memorial Hospital, Charleston, W. Va.

Submitted to the Publication Committee, November 5, 1959.

The questionably palpable mass in the right upper quadrant of the abdomen was a little more definite now than previously.

The hemoglobin on admission was 38 per cent. An intravenous pyelogram and a barium enema were reported as normal except for the suggestion of a small, soft tissue mass below the right kidney.

Following adequate preparation, the patient was taken to the operating room with a tentative diagnosis of metastatic carcinoma of the colon (second look operation). On opening the abdomen, a lesion involving the jejunum, approximately 18 inches from the ligament of Treitz, was observed. An approximate 30 cm. length of jejunum and its mesentery was resected. There was one large lymph node at the root of the mesentery.

Grossly, the tumor appeared to be new, and unrelated to the previous carcinoma of the cecum. On opening the resected specimen, there was noted a large papillary tumor originating from the bowel wall, protruding into the lumen. The portion of jejunum proximal to the tumor was greatly dilated.

Histologic examination of the tumor revealed it to be a papillary adenocarcinoma with abundant mucoid secretion. In some areas it extended into the muscle layers but not to the serosa. The lymph nodes of the resected mesentery were free of tumor, with the exception that the large lymph node removed from the root of the superior mesentery was almost completely replaced by metastatic adenocarcinoma. The patient's postoperative course was without incident.

During the next several months the patient was examined at regular intervals for signs of recurrence. She remained asymptomatic, however, and continued to gain weight. In March, 1951, she was readmitted to the hospital for x-ray studies of the small and large bowel, all of which were within normal limits.

During the latter part of May, 1951, the patient was again admitted to the hospital for a diagnostic D & C because of irregular uterine bleeding of two month's duration. Microscopic examination of uterine scrapings revealed a noninvasive, multicentric adenocarcinoma of the endometrium. Total hysterectomy and right oophorectomy were performed. (According to the patient's history, she previously had undergone bilateral salpingectomy and left oophorectomy for the cure of inflammatory disease). Exploration of the peritoneal cavity and viscera failed to reveal any gross evidence of recurrence of the tumors previously removed.

Histologic examination of the uterus confirmed the impression of early uterine carcinoma. Postoperatively, the patient's hospital course was uneventful.

Since May, 1951, the patient has been under close observation in order that early evidence of recurrence might be detected and that a search for new tumors at their earliest stage might be made. At each visit, special emphasis has been placed on examination of the breasts. In addition, x-rays of the gastrointestinal tract and of the chest on several occasions have been interpreted as normal except for an active duodenal ulcer, in May, 1957, which responded to the usual ulcer regimen.

When last seen, in March, 1959, the patient was asymptomatic. Physical examination, with particular reference to the breasts, lungs, abdomen, pelvis and rectum, was normal.

### Comment

Of interest is the fact that in the case of one patient three distinct malignant primary neoplasms were diagnosed within a three-year period. Also of interest is the occurrence of the lesions before the patient had reached the age of forty years. In fact, she was only 36 years old at the time of the total hysterectomy for endometrial carcinoma. Stalker, in a review of the subject, found that in approximately 40 per cent of cases, all tumors developed after the patient had reached the age of 70 years. In a series of autopsies published by Warren,[4] of Harvard University, the average time interval between the first and second neoplasm was three years.

It is of no little interest that the patient in the present case is still living, free of tumor, eight years after resection of the jejunum for adenocarcinoma with proven metastatic lymph nodes. Carcinoma rarely is found in the small intestine, and the survival time is short. Pridgen[5] and his associates, in 1950, in a thorough review of the literature, found that approximately 500 cases of adenocarcinoma of the jejunum and ileum had been reported. Colcock and Adamson[6] report that in their series of cases of carcinoma of the jejunum and ileum, the over-all five-year survival rate was only 17.6 per cent.

### Summary

Of 100 cases of malignant tumor, it appears that in 5 cases another primary malignant tumor will develop later. It would seem, therefore, that in the case of the patient with a malignant lesion, there is a greater chance of the development of a second, unrelated primary malignant

lesion than there is of the development of a first such lesion in the normal individual. In the former, the index of susceptibility to malignancy must be greater. Evidently many physicians fail to realize this and while following a patient for his initial lesion will overlook for too long a period a second tumor. We most certainly were guilty of this type of thinking in the early management of the present case. Fortunately, however, all has gone well to date. Constant vigilance and proper evaluation are necessary in order to detect early evidence of recurring malignancy, and of equal importance, in our opinion, is the search for new malignant lesions at their earliest stages in all cancer patients.

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# Communication

Communication is defined as an interchange of thoughts, and as a conference for the joint possession of something intangible such as news, opinions or intelligence. It is above all a sharing, with benefits deriving to each participant. It may contribute to "good public relations," but should not be considered synonymous, for public relations is more in the nature of advertising or promoting the good points of a profession or company without interchange of views.

As physicians, our most frequent communication is with patients. Although each of us has developed his methods of history-taking and of discussing diagnosis and treatment, it is worth reminding ourselves that not all communication is verbal. To the observant physician, the patient may betray many emotions, including anxiety or grief, by his posture, his blushing, the avoidance of certain subjects, or by inappropriate answers. Conversely, the physician, by unguarded shrugs, frowns, and the like, may convey unintended criticism or concern to an overly sensitive patient.

In all discussions between doctor and patient, it is essential that each understand the other. The patient should be asked to explain unfamiliar slang phrases, and should be encouraged to ask for simple definitions of medical terms he does not understand. "Cardiospasm" may be as insignificant as a hiccup to the physician, but unless the term is avoided or is clearly explained as pertaining to the gastrointestinal tract, its use might well convince the patient that he has heart disease. Or consider the plight of the young man seeking a circumcision who expressed himself so poorly that a vasectomy was performed. A few moments spent in defining terms—in the true communication—would have prevented such a catastrophe. A blackboard, models or simple pictures will often assure complete understanding of technical terms.

The doctor must also be aware of the adeptness in communication (or lack of it) by the personnel in his office, who are so closely identified with the doctor himself. A cheerful receptionist who greets the patient by name, and the sympathetic nurse who often obtains bits of information not proffered the doctor, can both be assets in promoting adequate communication between doctor and patient.

These may be considered petty points, but unless adequate communication is established between physician and patient, not only is first-rate therapy impossible, but the prestige of the entire medical profession suffers.—J. M. P. in Journal of the Florida Medical Association.

# Chronic Multiple Hemorrhagic Telangiectasia

## (Case Report)

*E. L. Walsh, M. D.*

The following case is reported because of its interest from several standpoints. I shall not go into detailed discussion of hereditary hemorrhagic telangiectasia (Rendu-Osler-Weber disease) since it has been described in detail in a number of well prepared articles in the current medical literature. Early descriptions were by Sutton in 1864, Legg in 1876, Rendu in 1896, Osler in 1901, and Weber in 1907.

Hereditary hemorrhagic telangiectasia is a vascular anomaly characterized by multiple dilatations of capillaries and venules of the skin and mucous membranes transmitted as a simple dominant factor, not sex-linked, affecting both sexes. Histologically, the telangiectasia has a thin, vascular wall consisting of a single layer of endothelium lying just below the thinned-out epidermis. The blood picture usually is normal except for secondary anemia. Clinically, telangiectasia is characterized by the lesions frequently being present during infancy and childhood, with the onset of hemorrhage from these lesions occurring during puberty; the symptoms and signs, however, reach their maximum by the fourth decade of life. The bleeding often is attributed to some other disease such as peptic ulcer, or blood dyserasia. The telangiectasia are found most frequently about the face, especially the nasal mucous membrane, but may occur in any organ of the body. Repeated epistaxis is the most frequent symptom and it may precede any visible sign of telangiectasia. Hemorrhage may occur from the gastrointestinal tract or the urinary tract.

Treatment generally is unsatisfactory, and blood transfusions along with tamponage for loss of blood, are the only generally accepted treatment methods. Electrocoagulation may give good results.

### Case Report

The patient, a World War I veteran, was a 46-year-old white male, an American, who worked for the FBI, and who had the first of a total of 23 admissions to the Veterans Administration Hospital, Huntington, West Virginia, for treatment of secondary anemia as a result of severe nasal hemorrhages. The first admission preceded the patient's death by 19 years. He was extremely anemic, moderately dyspneic, and weighed approximately 260 pounds. He had received innumerable transfusions (an estimated 50) in private hospitals before his first admission to the Veterans Administration Hospital.

The history obtained indicated that the patient's father had had lesions of the same type, also bleeding, the latter having started when he was 30 years of age. He had been attended by Dr. William Osler who had considered his case sufficiently interesting for presentation in Europe, and had planned to take the father to Europe with all expenses paid. Shortly before they were to leave, however, the father had had a severe hemorrhage from the nose and had died (aged 63 years).

No other members of the patient's family had had any similar trouble, neither on the mother's side nor on the father's.

The patient, in 1914, while playing big league baseball, first noticed hemorrhages from his nose, but they did not occur frequently nor were they severe. In 1918, he had rather severe hemorrhages from the nose, and some oozing of blood almost every day. These symptoms persisted off and on until July, 1936, when he began having hemorrhages from the stomach, also tarry stools. The attacks of bleeding were precipitated by hard coughing, sneezing, and undue excitement or anger.

This man had had anemia for several years and the disease had become much worse a few months before his first admission. Prior to World War I, he supposedly had a "growth" in his nose and was operated on for this while in service. Instead of improving, however, the condition became worse and the episodes of bleeding from the nose more frequent.

Submitted to the Publication Committee, December 17, 1959.

*The Author*

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Physical examination at the time of the first admission was essentially negative except for pallor from anemia. Eye, ear, nose and throat examination was reported as negative except for absence of a large portion of the nasal septum. Blood pressure was 126/54. RBC 910,000, WBC 8,200 with polymorphonuclear neutrophils 76 per cent, lymphocytes 16 per cent, and monocytes 8 per cent. Hemoglobin was less than 10 per cent Sahli. Anisocytosis and poikilocytosis were present. Coagulation time was 4½ minutes and bleeding time 4 minutes. The patient received three blood transfusions on this admission.

The next twenty-two admissions, over a period of 17 years, were for secondary anemia due to epistaxis, hematemesis and melena. During the second admission many small, reddish, mole-like lesions of the ears were noted. Gastrointestinal series and barium enema were normal.

Telangiectatic lesions appeared over the face, lips and tongue, progressively more marked with each hospitalization. One and one-half years prior to death, the right external carotid artery was ligated in an attempt to stop the daily bleeding from the nose. By this time, his twenty-second admission, inclusive, the patient had received 401 blood transfusions for treatment of the severe secondary anemia.

The twenty-third (final) admission was three days after the patient's last AWOL discharge and was for the purpose of treatment for severe epistaxis and hematemesis. During this hospitalization he had severe hemorrhages from the nose, also from the gastrointestinal tract and, to a less severe extent, from the ears and into the macula of the right eye. In the course of a particularly severe, prolonged hemorrhage from the nose, he became comatose and was irrational for four days.

Prior to his Veterans Administration Hospital admissions, he had had cut-downs on veins, with ligation of the veins, and so it was that we soon had difficulty finding one for transfusion. During the last few months of his illness we had to use the femoral veins, the veins of the penis, and sternal marrow transfusions. The patient received as much as 1500 cc's. of blood per day and was transfused many times on successive days, with a few reactions of fever and, occasionally, a chilly sensation.

During his last 2 years of life, this patient's hemoglobin averaged 3 Gm., often being 1.5 and 2, rarely up to 6 Gm. Bleeding became more profuse if it rose to 6 Gm. or more. On various admissions iron, liver, rutin, vitamin P and Adrenosen Salicylate were given. Late in his illness there was evidence of cardiac failure, and he was digitalized. Daily epistaxis developed, also frequent hematemesis and melena. He expired during this, his twenty-third, Veterans Administration admission, 19 years from the time of his first admission to the hospital. On this last hospitalization he received 70 transfusions. The total number of this patient's blood transfusions over the entire period of his illness was 501.

Figure 1

Figure 2

Figure 3

**Figure 1. Left ear showing multiple large telangiectasia. Taken one year before death.**
**Figure 2. Right ear showing multiple telangiectasia. Taken one year before death.**
**Figure 3. Many areas of telangiectasia can be seen in the tongue. Picture taken one year before death.**

Figure 4

**Figure 4. Smaller areas of telangiectasia can be seen in the nose and face. Picture taken one year before death.**

### Autopsy Findings

Interesting findings at autopsy were as follows:

The entire skin was studded with reddish dots which were more prominent on the chest and face. The ear lobes were bumpy and studded with reddish knobs, some of which were 1.5 cm. in diameter. The oral cavity showed reddish spots. The nostrils showed a reddish or hemorrhagic area covered with bloody crusts. On the neck were reddish spots which were elevated and warty. The liver edge was palpated one fingerbreadth below the xiphoid process. The spleen also was palpated. The extremities were bespeckled with reddish, warty dots. There was 2 plus ankle edema.

The heart was greatly enlarged, weighing 775 Gm. The coronary arteries were markedly changed, the left showing a pinpoint lumen which continued as such up to the lower third of the descending ramus. The remaining portion of the descending ramus was delicate. The same was true of the right coronary artery.

The esophagus was bespeckled with slightly elevated reddish dots ranging from the size of a pinhead to that of a small pea. Near the cardia several dots showed erosion, obviously representing bleeding spots. The stomach was large and on being opened was found to contain two quarts of black, bloody material. The mucous membrane was fossulated and showed numerous projected pinhead to pea size reddish dots, some of which were eroded. On incising they appeared reddish and spongy. Similar lesions were found throughout the length of the small intestine and a few in the large intestine.

The liver was greatly enlarged, weighing almost 2700 Gm. It was dark brown-yellow in color and of firm consistency, with a dull inferior margin. The surface was bespeckled with hemorrhagic dots. On cut surface hemorrhagic islands which were very small were scattered throughout. The pancreas was not remarkable save for some hemorrhagic areas ranging up to pea size near the tail. The spleen was enormously enlarged, weighing 900 Gm. The cut surface was firm, dark blue-brown-red. The left suprarenal gland showed a small walnut sized cortical tumor. The left kidney showed a few hemorrhagic spots. The right kidney was occupied by a tangerine sized, well defined, hemorrhagic tumor of orange color. The tumor did not involve the kidney pelvis and had not invaded the renal vein.

### Microscopic Examination

Microscopic examination of the alimentary tract, skin, liver, pancreas and kidneys showed groups of dilated venous blood vessels representing the basic pathology of the disease. In addition, there were myocardial fibrosis, coronary arteriosclerosis and an incidental finding of hypernephroma of the right kidney. There was no evidence of hemachromatosis.

### Summary

A case of chronic multiple hemorrhagic telangiectasia in a white male who was 65 years of age at the time of his death is presented, along with clinical and pathologic study. The course of the patient's illness was marked by severe epistaxis, hematemesis and melena. In this particular case large and small veins were primarily involved, and no involvement of the arterial system was demonstrated.

The symptoms of chronic multiple hemorrhagic telangiectasia may be varied, depending upon the site of the lesions. Local treatment such as excision is of value, mainly to stop the bleeding. Arteriovenous shunt is noted in some cases but no evidence of this procedure was observed in the present case. This patient, however, did have cardiac decompensation late in the course of his illness and at times cardiac pathology and decompensation are the results of arteriovenous shunt. Some observers may question the rationale of so large a number of transfusions in a single case. Until the last seven years of his life the patient had not received many blood transfusions and had remained comfortable and active. During the last two years of his life, the hemoglobin was maintained

at an approximate average of 3 Gm., which certainly is minimal in the extreme. More transfusions were not given during this period because whenever the hemoglobin got as high as 6 Gm. bleeding would start immediately.

At times, patients who have received many transfusions show evidence of hemachromatosis but in this case the patient did not.

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# Gobbledygook and the 'Ologies'

A wise old New Englander, himself a master of clear and convincing expression, once said to his teenage grandson, "Never use a fifty-cent word when a ten-center will do."

In this connection a story that is probably entirely without foundation has it that once the late President Eliot of Harvard ran aground on a reef while canoeing and shouted to friends on the shore, "I was aware of the proximity of the rock but had miscalculated the force of the tide." Another more striking example is the absurd remark of the little girl who was told to keep her baby brother away from the water. Innocently aping the conversation she was used to hearing on the part of her father she cried, "Oh, Daddy, Daddy, come quick, Johnnie is adjacent to the perifphery of the mill pond."

At a hospital recently a visitor who had come to study staff activities asked the Administrator, "Do you think the members of your staff will be upset if you apply the penalties listed in your rules?" This was the answer, "The implementation of sanctions will inevitably eventuate in subsequent repercussions." In other words, "Yes."

Such language is silly in conversation and why must we use it in scientific articles except when it is needed to express an exact meaning that cannot be stated in simpler terms? Why must we use a style that is stilted and often even obscure to the casual reader.

In a leading article recently published in a venerable medical journal, a paragraph begins, "Phenomenologically the—Syndrome is," etc. Phenomenologically! What a word! On the basis of what we have been saying it rates at least a value of a dollar and fifteen cents. And there are many "ologies" in more common use than is phenomenology (described as the science concerned with the study of phenomena) than which nothing could be more general, one would suppose. Consider this question on an examination paper, "Describe the methodology used in studying the symptomatology and the pathology in the affected tissues." What the professor meant was, "Describe the methods used in studying the symptoms and the lesions in the affected tissues."

Usage, it is said, makes language and, sad to say, it may be that in time the "ologies" used as described may be considered correct. At present, at least, methodology means the science and study of methods, and symptomatology the science and study of symptoms. In the same way pathology is a science, not a condition, as we all know. We can confirm these facts by consulting our dictionaries. Should we go out of our way to add new and strange meanings of words in an abortive attempt to make our language sound impressive and technical? Should we not rather make it a rule to say in as simple and straight-forward a manner as possible exactly what we mean—deploring contemporaneous manifestations of sesquipedalianism?—Rhode Island Medical Journal.

# The Management of Cataract Surgery And Its Complications*

*Murray F. McCaslin, M. D.*

I AM presenting here the points I consider essential in the management of cataract surgery and its complications, but I do not propose to go into the details of techniques.

### Preoperative Preparation

Once the diagnosis of operable cataract has been established, it becomes essential that a thorough physical examination be made to determine the classification of the patient with regard to surgical risk. If general anesthesia is to be used (and I do 99 per cent of my patients under a combination of intravenous Pentothal® and local), the following simple tests are employed for classification purposes:[1]

1. *Moots's Index:* This formula provides an approximate index to the cardiac reserve. (It is likely to be unreliable in cases of thyrotoxicosis because of the high pulse pressure).

$$\text{Moots's Index } \frac{\text{Pulse pressure} \times 100}{\text{Diastolic pressure}} = 50 \text{ approximate in normal subjects.}$$

Patients showing an index from 25 to 75 probably have adequate cardiac reserve, with 40 to 60 as the optimum figures. Below 25 and above 75 the reserve is gravely inadequate.

2. *Energy Index:* This gives an approximate measure of the circulatory reserve, being a product of cardiac energy and diastolic vascular resistance.

Systolic Pressure + diastolic blood pressure × pulse rate = energy index.

The first two figures of the answer are taken, the product being expressed in millimeters of mercury per minute, e. g., 17,300 means energy index is 17.

Values between 6 and 24 indicate satisfactory circulatory energy, with 12 to 18 as the optimum or more nearly normal. Below 6 and above 24 indicate a grave deficiency in circulatory energy and correspondingly poor risk. This test applied soon after the operation will frequently give an accurate clue to the prognosis.

*Presented before the 12th annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, at The Greenbrier in White Sulphur Springs, June 8, 1959.

Submitted to the Publication Committee, December 22, 1959.

## The Author

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3. *Henderson's Test:* This test provides an approximate measure of vital capacity. It is dependent upon the size and age of the patient, his athletic habits, and the condition of his lungs.

To make the test, the patient lies absolutely quiet for five minutes; he then takes a moderately deep breath and holds it as long as possible, lips closed, nostrils pinched together. A normal subject should be able to hold his breath under these conditions for 45 seconds; 30 seconds would indicate good vital capacity, progressively decreasing to 12 or 10. Below this, gravely impaired vital capacity, with possible cardiac involvement, is indicated. Such a patient would be classed as a poor or subnormal risk.

Among other pertinent points to be specifically investigated when obtaining the patient's history is that of allergy. At the Eye and Ear Hospital of Pittsburgh we use a special form for allergy and this is completed on all patients.

Adequate preparation for cataract surgery is of paramount importance regardless of whether the procedure is done under local anesthesia or a combination of local and Pentothal® given intravenously. Pentothal® should not be chosen unless you have a competent anesthesiologist versed in its use. It is an ideal adjunct to cataract surgery because it can be tailor-made to fit the patient's needs but, like all potent agents, its use is predicated on a precise technique for this particular operation, and intubation does not belong in this technique. I might add that it should not be used by one whose operative technique requires more than one-half hour.

The usual preoperative orders consist of Seconal® grains 1½ the night before, to insure a good night's rest. One hour before operation, Seconal® grains 3 and Vesprin® 10 mg. intramuscularly are given. Forty-five minutes before

operation, the patient is given, hypodermically, Demerol® 100 mg. and atropine grains 1/100. The involved eye is prepared in the patient's room, by the nurse, and a sterile patch applied. At this time, one-half hour preoperatively, one drop of ½ per cent Pontocaine® is instilled in the eye and the procedure repeated every ten minutes.

In the operating room the eye is again given a thorough cleansing of the skin using green soap and is then washed with distilled water. The cul-de-sac is irrigated, a drop of 10 per cent argyrol is instilled to congeal any mucus, and the eye is irrigated again.

An O'Brien and Van Lint akinesia is made by using 2 per cent Novocain® or Monocain® and if only local is to be used a retrobulbar injection of 1 or 1½ cc's. of 2 per cent Novocain® or Monocain® to which has been added Alidase® (150 units per 20 cc. of local anesthetic agent); mild compression is then applied to the eye for ten minutes.

For congenital cataract I prefer to do a two-stage operation. First, a discission is performed using a short, small, hawk-bill-shaped knife. With this type of blade it is easy to penetrate the lens and the shortness of the blade minimizes the possibility of penetrating the posterior capsule. Recently we have been using Fluothane® as the inhalation anesthetic of choice for children. This agent has rapid onset and recovery time, with no nausea. A week or so later the second stage, or linear extraction, is performed under general anesthesia, using ether for very young children. We use Avertin® and ether for older children. I always use a conjunctival flap to cover the corneal section, made up in the cornea a millimeter or more from the limbus. This section is made up in the cornea to prevent postoperative hemorrhage and to minimize prolapse of the iris. The conjunctival flap gives added protection to the area and assures firm coaptation of the edges of the corneal section. After operation cuffs are applied to the arms and a mask or shield is applied over the eye.

Traumatic cataract can vary so in nature that each case dictates its own procedure.

Dislocated or subluxated lens was a subject discussed by Agnew,[2] in 1885, and at that time he advocated fixing the lens in the anterior chamber by inserting two pins through the pars plana. This method was revived recently by Barraquer, of Bogata, and Calhoun[3] has reported eleven cases of subluxated and six cases of luxated lens. In this recent series, in the only cases that had cauterization of the pin sites there developed an intra-ocular hemorrhage on the fifth postoperative day. In the cases in which the vitreous face keeps the lens forward and the pupil doesn't dilate well, I have had success with an operation consisting of corneal section with a conjunctival flap, three to five corneoscleral sutures, peripheral iridectomy made into a complete iridectomy with De Weeker scissors and through this opening I introduce two sharp spears to fix the lens at the equator and then extract it.

When the lens is completely dislocated into the posterior chamber, hypermature cataract and secondary glaucoma may develop. These cases will show mild cyclitis with cells in the anterior chamber. When the elevated tension is uncontrolled by medication Chandler[4] recommends that the lens be removed by irrigating the posterior chamber with normal saline solution.

Secondary glaucoma can also be produced by a hypermature cataract with the lens *in situ*, the lens material escaping through the posterior capsule and setting up the inflammatory reaction of the eye, presenting problems that have to be resolved on an individual basis.

Regarding monocular cataract it is my opinion that if the person's work does not demand binocular vision he can be carried along for some time so long as the intraocular pressure in the affected eye remains normal. When an individual's work requires that he have peripheral vision on the restricted side, then cataract extraction is justified although a lens may not be prescribed postoperatively. If single binocular vision is to be preserved, before the exotropia becomes established, cataract extraction is justified if the patient is willing to be fitted with a contact lens postoperatively. Corneal contact lenses, in my opinion, should not be fitted to a postoperative cataract patient until at least four to six months postoperatively. If he adapts himself well to the corneal lens it can be worn regularly. If he experiences some difficulty, the use of the corneal lens may be restricted to only a few hours a day to maintain single binocular vision.

Alpha Chymotrypsin was first used by Jenkins,[5] in 1955, when he irrigated the posterior chamber of the eye for vitreous opacities and found that the lens luxated into the anterior chamber. He subsequently used the drug in cataract extraction. Since the report by Barraquer,[6] of Barcelona, the drug has become more popular and certain principles have developed which make its use today almost routine. It can be used in patients beyond the "teens" and in those over fifty who have had

difficulty with cataract extraction in the other eye. In the former group the cataract was extracted extracapsularly almost routinely, but now intracapsular extraction is the order of the day. Patients in the "teens" are undesirable due to the adhesions of the vitreous to the posterior lens capsule or the hyaloideocapsular ligament of Weiger.

Alpha Chymotrypsin comes in crystalline form and when the diluent is added to the vial it makes up to 1/5000 per cent or 150 Armour units per cc. The technique requires that all blood be removed from the anterior chamber because trypsin is inactivated in the presence of red blood cells. The trypsin is introduced by irrigation beneath the iris, and after a period of two minutes the cement substance is dissolved in the fibers of the zonule, they lose their power of traction, and the lens curvature changes. In other words, it appears to move forward.

If one is dealing with an eye which is known to have a fluid vitreous, the forceps or erysiphake may be applied before irrigation. Tumbling with an erysiphake produces less corneal damage and there is less likelihood of vitreous loss, but in many cases the lens can be removed by depressing the lip of the corneal section and a simple extraction performed. If vitreous is found to be adherent, it can be stripped off with a spoon or hook. After the lens is removed it is advisable to irrigate with normal saline immediately after the extraction. The immediate post-operative result seems to be excellent. Low-grade uveitis, however, has been reported,[7] along with keratitis. I think that the striped keratitis that may occur probably is due to irritation of the endothelium by the erysiphake itself. Delayed healing of the endothelium at the incisional area has been reported to be more frequent than in those cases in which the operation was performed with trypsin. In my short experience with this drug I have seen no ill effects.

When faced with cataract removal in the presence of Fuch's dystrophy, that dystrophy characterized by grayish, round Hassall-Henle bodies on the posterior cornea, I thing it best to delay the operation as long as possible for we know that the condition does increase after cataract extraction. When forced into removing a lens in the case of one of these unfortunate individuals it is best to make a scleral section causing as little trauma to the cornea as possible.

Extraction after a successful glaucoma operation presents the problem of a choice of sites for the corneal section. In my experience I have found it best to preserve the bleb by carrying the corneal section in front of the bleb. On some occasions I have found it quite advantageous to do an inferior corneal section and have noted that the patient does just as well as with the classical incision above.

Expulsive hemorrhage at the time of operation is, of course, a major catastrophe, and one which all of you will experience at one time or another if you do enough surgery. Henderson[8] reports that while operating on the remaining useful eye in a certain case, he noticed immediately after the lens extraction a dark bleb forming above. This was followed by vitreous bulging. He did a sclerotomy above and repeated it when the hemorrhage re-formed. The eye did well and recovered 20/30 vision. Seven years later he did a cyclodiathermy for secondary glaucoma. This is, I am sure, a very unusual case, and I suspect that not many of us are as alert as he was on that particular day.

A complication of local anesthesia in cataract surgery is retrobulbar hemorrhage. When this occurs, it seems to me that the only course to follow is to apply a pressure bandage and wait until the hemorrhage is completely absorbed before making another attempt.

Next, I shall discuss the poorly fitting speculum, which produces an increase in the intraocular pressure. In my experience, this accounts for more loss of vitreous than any other single manipulation at the time of operation. It behooves all of us to check our speculi and see that they are well fitting, producing no pressure on the globe. For this reason I use modified Castroviejo lid clamps. As a matter of fact, I use only one, for the upper lid, and have found this to be a very satisfactory procedure when combined with a superior rectus tendon retraction suture. In certain cases, the superior rectus tendon retraction suture is sufficient.

Poor fixation can get one into a lot of difficulty because its existence usually is not known until the start of the corneal section and then one finds that he really is up again it. This is where the well trained assistant can be of valuable help in fixing the eye by grasping with a forceep one or the other medial and lateral recti muscles.

A section for cataract placed too deep down into the sclera always is associated with considerable hemorrhage. Controlling the hemorrhages consumes a lot of time, since the operation cannot be continued until this is accomplished.

I am sure you have all had the experience of performing an iridectomy or an iridotomy with scissors that are not sharp, and of finding that by

not watching your scissors when removing them from the incisional area you have produced a much wider iridectomy than originally planned.

Regardless of how steady one may appear during section of the cornea or during iridectomy or iridotomy, it seems that when one applies the forceps to the lens the adrenalin secretion increases and a tremor will make itself evident, resulting in what I term "spastic removal of the lens." For this, there is only one remedy: Give some thought to yourself, get steadied down and overcome it for it is strictly an emotional disturbance which clears up with experience. This is always a problem that one has to contend with in training a new resident.

Another complication is poor closure of the incisional area as a result of not paying particular attention to the placement of sutures. This is just a matter of observation. If the sutures are lined up properly, one has made the first step towards an adequate closure. If a conjunctival flap is part of the corneal section, see that it is replaced properly and not folded under on itself. The position of the iris pillars is easily detected if one will only look.

Lastly, the dressing. I think that a firm patch adequately applied is the best insurance against many postoperative complications, particularly so, if the patient has a tendency to be nauseated or to cough postoperatively.

### Postoperative Complications Of Cataract Surgery

At the first dressing postoperatively whether it has been the first, second, third or fourth postoperative day, delayed restoration of the anterior chamber presents problems of concern. The usual causes are a leaking wound due to inadequate closure, sutures placed too deep, or vitreous, cortex or iris in incarcerated in the wound. Any of these, if properly recognized, can be repaired. There is a group that can be attributed to suppression of aqueous, either from surgical shock described by Kronfeld[9] or another group described by Miller, Keskey and Becker[10] that demonstrated a state of hypotomy with an associated decrease facility of outflow which persisted for from six weeks to one year. Eyes with pre-existing glaucoma did not vary from nonglaucomatous eyes. One can get a false sense of security in the glaucomatous eyes, hence, they need frequent watching to determine when secretion is reestablished. Twenty-five per cent of the patients with established aqueous formation were uncontrolled by their preoperative medication.

It is of interest that following an uncomplicated cataract extraction, many eyes have more synechiae and a decrease in outflow facility, but of insufficient degree to induce secondary glaucoma. It is only in those eyes in which synechiae and decrease facility of outflow are marked that glaucoma becomes a frequent occurrence. If persistent hyposecretion exists, glaucoma is avoided.

Hughes and Owens,[11] in their statistical comparison, found secondary glaucoma three times more frequent following extracapsular extraction, also that patients with diabetes of long standing or those requiring 30 units of insulin daily are more likely to have anterior chamber hemorrhage postoperatively.

Goar[12] describes a condition of loss of anterior chamber 11-29 days postoperatively which he believes is due to the aqueous getting back of the vitreous and pushing it forward. He suggests retrobulbar injection of Novocain,® adrenalin and hyaluronidase, along with a T-shaped incision through the pars plana to allow the escape of aqueous, then the injection of air into the anterior chamber followed by pilocarpine and a patch. Diamox is unsuccessful.

Choroidal detachment has to be considered and can be detected by direct ophthalmoscopy. It, however, is not always associated with a flat chamber.

Certain criteria can be established which govern one's actions, namely, the less inflamed the eye, the longer a flat chamber can be tolerated. In one particular case in this category, three months elapsed before the chamber reestablished itself. I have followed this case for fifteen years and still the patient has 20/20 corrected vision, with no complications. The healthier the posterior surface of the cornea, the longer a flat chamber can be tolerated. With inflammation and a diseased endothelium, however, it is more likely that there will develop a peripheral or anterior synechia, vitreous adhesions with associated corneal edema, or a ring synechia of the iris to the hyloid which may be the onset of pupillary block glaucoma.[13]

The treatment indicated in the presence of a shallow anterior chamber immediately postoperatively is watchful waiting, repair of leaking wound or air injection. Administration of Diamox or its related drugs is of questionable value. I have found that many chambers flat on the first dressing are formed by the next dressing if one has touched the conjunctival edge of the flap with 1 per cent silver nitrate. This has happened too often to be a chance case in point.

Factors inducing secondary glaucoma are remains of the capsule in the angle, hyphemia, which has to be removed if the anterior chamber

is blocked else pupillary block occurs, flat or shallow anterior chambers which persist sufficiently long to produce angle closure and loss of vitreous with vitreous obstructing the angle.

Postoperatively, iridocyclitis is a normal reaction to trauma or may be induced by incarcerated material in the incision, or may be a reaction to retained lens cortex and the most severe of this phenomenon is phaco-anaphylaxis.

Endophthalmitis after cataract surgery requires reevaluation of the physical status because, in my experience, it is the result of endogenous reaction to streptococcic infection elsewhere. Rarely if ever is it the result of direct contamination. For this reason a recheck of teeth, tonsils, sinuses, prostate or cervix is in order with primarily a careful scrutiny for devitalized teeth. After these possibilities can be eradicated or ruled out, the teratment should be chloromycetin orally and subconjunctivally with ACTH I. V., 40 units made up in 1000 cc's. of water and 5 per cent glucose, given at the rate of 25-30 drops per minute daily for at least six days.

Sympathetic ophthalmia is rarely seen, but it is a definite complication which responds best to heavy and prolonged steroid therapy.

Retinal separation will follow cataract extraction primarily because it is associated with vascular changes on or near the ora in persons of that age group in which one expects to find abnormal vascular changes. Maumenee[14] reported that in 22 per cent of all retinal separation cases the patient had undergone cataract surgery and that in 25 per cent of these it had been within three months and in 50 per cent within one year. The incidence was the same between intracapsular and extracapsular. Schepens[15] reported the separation occurred at the ora serrata in 66 per cent of his cases, while Welch[16] found that 75 per cent had tears at the equator. In our experience, scleral buckling associated with electrocoagulation has been the most effective procedure.

Corneal edema immediately following a cataract operation is indicative of a poor closure. The persistence of edema likewise may indicate the same condition, but may be also an expression of excessive trauma at the time of the operation or it may be an aggravation of previous endothelial conditions such as Fuch's dystrophy, changes due to long standing uveitis, glaucoma, or a penetrating graft. If these can be excluded careful inspection may reveal the vitreous in contact with the endothelium, and herniation into the anterior chamber. If such be the case one has to consider drainage of the vitreous through an incision in the pars plana and injection of air, if it be of recent origin, or, if it is of some duration, mechanically remove the vitreous through an incision at the corneoscleral angle and replace it with air, closing the incisional area with fine sutures.

**Conclusion**

In conclusion, it might be said that adequate treatment and good technique ward off many problems, also that early recognition and prompt institution of treatment in those that do arise will insure an extremely gratifying rate of successful results.

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# Ruptured Interstitial Pregnancy Following Bimanual Examination*

## (Case Report)

*A. J. Villani, M. D., and R. H. Edwards, M. D.*

Interstitial pregnancy is the growth of a fertilized ovum in the interstitial portion of the tube. Frequently, the term "interstitial pregnancy" is used interchangeably with cornual pregnancy and angular pregnancy. There had been 199 cases of interstitial pregnancy reported by the year 1943 (Grusetz and Polayes). Ash,[1] in 1932, reviewed the literature and reported eight cases which had been previously reported by Richardson.[2] D'Errico,[3] in 1937, brought the literature up to date and reported only 23 cases, including one of his own. A case similar to the one reported by Speck and Halter, that of an interstitial pregnancy following salpingectomy for ruptured tubal pregnancy, was reported by Ballantyne[4] et al, in 1940. Another case was reported by Buerger and Weinstein,[5] in 1948, with the additional interesting information that their patient later conceived and was delivered uneventfully by caesarean section, in 1952. Leverton[6] reported the most bizarre case to date, that of an interstitial pregnancy following two previous salpingectomies, all on the same side. The first salpingectomy had been for chronic salpingitis and the second, three years later, for a tubal pregnancy.

*Presented before a meeting of the West Virginia Obstetrical and Gynecological Society, held during the annual meeting of the West Virginia State Medical Association, at The Greenbrier in White Sulphur Springs, August 24, 1956.

Submitted to the Publication Committee, February 4, 1960.

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Recently, several cases have been described. Saave[7] reported in the *Medical Journal of Australia,* a case of ectopic interstitial pregnancy followed by an explosive rupture of the uterus. This was in a 37-year-old half-cast woman, half Chinese and half New Guinea negro. She had three living children, one of whom had died soon after birth, and she had had one miscarriage.

The patient had a history of a previous ectopic pregnancy in the left tube. There had been no vaginal bleeding at any time but there was sudden severe collapse. Speck and Halter reported a case of interstitial pregnancy following tubal pregnancy with a review of the literature in *Surgery, Gynecology and Obstetrics* (March, 1956). This was in a 31-year-old white patient, para I, gravida III, who had had an uneventful pregnancy in 1948. She had an ectopic pregnancy with left salpingectomy prior to the interstitial pregnancy.

**Figure 1. Placenta and amniotic sac as removed from the pelvic cavity.**

**Figure 2. Placenta with opened sac revealing the 6.5 centimeter fetus.**

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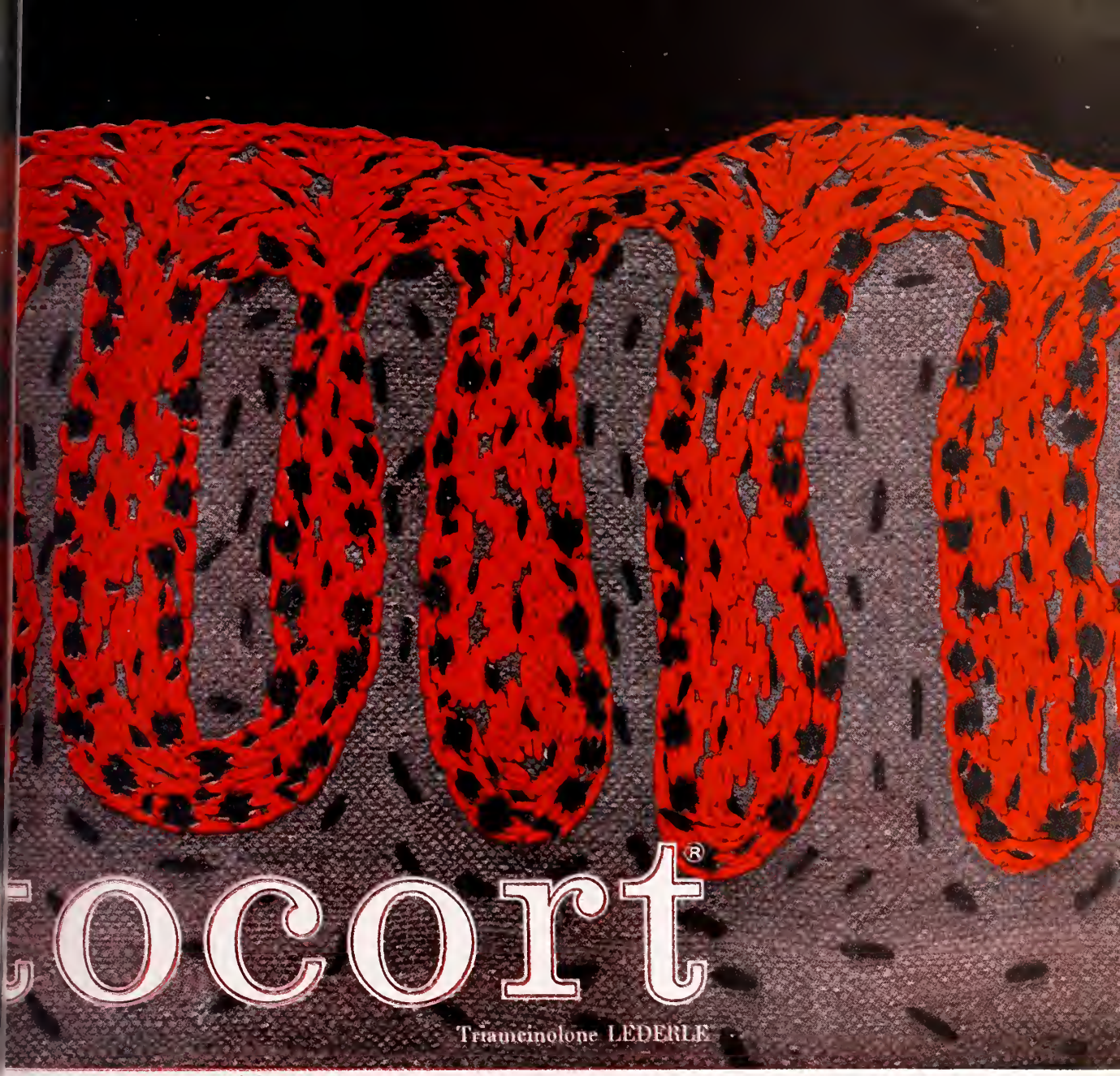


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### Case Report

Mrs. H. H., a 34-year-old white patient, para VII, gravida X, history of two abortions, last menstrual period March 27, 1956, had had an uneventful pregnancy in 1955 and delivered a full term, living female infant on May 1 following manual rotation of a left occiput posterior.

A year later, on the night of May 27, 1956, she was admitted to the hospital, having been referred by her local physician as "pregnancy, abdominal pain; possible threatened abortion." She gave a history of onset of abdominal pain at 3 A. M., May 27, 1956, following sexual intercourse. The day previously, the patient had helped her husband install a new motor in a jeep, that is, she performed the "cranking" involved. Her pregnancy had been uneventful prior to this date and without any bleeding.

Physical examination on admission revealed a well developed, well nourished, white female complaining of abdominal pain. Her blood pressure was 110/60; pulse, 78; temperature, 99.6. There was definite tenderness in both lower abdominal quadrants, apparently more marked on the right.

She was observed closely for twenty-four hours. Her hemoglobin on the morning of May 28 was 70 per cent; RBC, 3.60 million; WBC, 5,200. Differential showed stab cells, 3 per cent; segmented, 79 per cent; lymphocytes, 15 per cent; eosinophils, 3 per cent. Blood type A, RH factor positive. A catheterized specimen of the urine revealed 8-10 pus cells.

The patient was seen in surgical consultation on the morning of May 28, 1956, at which time pelvic examination revealed no vaginal bleeding; the cervix was smooth; positive Chadwick. Bimanual examination showed the uterus to be enlarged to the size of 2-3 months' gestation, and soft; there was rather marked tenderness, however, in the adnexa bilaterally and tenderness of the uterus; no masses were palpable in either adnexa.

Thirty minutes following the pelvic examination, the patient went into shock, the blood pressure falling to 60/40. The hemoglobin dropped to 8 Gm. Sahli or 47 per cent.

The patient was prepared for immediate laparotomy, with the tentative diagnosis of ruptured ectopic pregnancy. Exploration through the abdominal incision revealed the pelvic cavity filled with free and clotted blood. The right tube and ovary and left tube and ovary were normal and intact. There was a rupture 1-5 Cm. in diameter in the cornu of the uterus on the right. The blood, clots and an intact amniotic sac and placenta (8-10 weeks' gestation) were removed. The patient was given blood autotransfusion, approximately 300 cc's. The opening in the uterus was closed in layers and the tubes were bisected. The abdominal cavity was closed in the usual manner.

Two additional whole citrated blood transfusions of 500 cc's. each were given, following which she had an uneventful postoperative convalescence and was permitted to return home on June 5, 1956. Her hemoglobin following the blood transfusions rose to 74 per cent and the red cell count to 3.72 million.

### Pathological Report

Specimen: Fetus and placenta. Gross: The specimen consists of a placenta and an intact amniotic sac measuring 7 x 6 x 3 centimeters. Within the sac is a 6.5 centimeter grossly normal fetus. The entire specimen has been fixed in formaldehyde. No microscopic examination.

### Summary

A recent case of ruptured interstitial pregnancy following bimanual examination is reported.

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*. . . the greatest remedy for anger is delay.*

SENECA.

# Present Status of the Drugs Used Less Frequently in Tuberculosis*

*James H. Matthews, M. D.*

It is generally accepted that the initial drug treatment of pulmonary tuberculosis usually should consist of two drugs given concurrently, one of which should be isoniazid. Isoniazid is the most effective, least toxic, cheapest and most easily administered drug presently available for tuberculosis treatment. In the usual case, isoniazid is given with para-aminosalicylic acid, often given as the sodium salt. Isoniazid and para-aminosalicylic acid have been shown by the Veterans Administration Armed Forces Cooperative Studies to be the most effective combination of drugs for treatment of moderately advanced and far advanced cavitary tuberculosis, although isoniazid alone may be perfectly adequate for treatment of minimal and non-cavitary, moderately advanced tuberculosis. The main problems associated with PAS have been gastrointestinal intolerance, hypersensitivity reactions, and difficulty of administration. Solutions of PAS deteriorate. Tablets require the use of 24 pills a day, which the patient often will not take regulary, and powders and granules are both cumbersome to use and expensive. Streptomycin also is effectively used with isoniazid and is relatively inexpensive, although there are several disadvantages. Since it must be given by intramuscular injection, it is less desirable from the standpoint both of patients and medical personnel. Although the dosage of 1 Gm. given twice a week at three to four day intervals may be satisfactory when streptomycin is combined with para-aminosalicylic acid, there is evidence that the streptomycin should be given daily, usually in 1.0 Gm. or perhaps in 0.5 Gm. doses when used with isoniazid because the twice weekly schedule of streptomycin is thought to be less effective than the daily dose in preventing the emergence of organisms which are resistant to isoniazid. Streptomycin is also associated with a moderate incidence of toxicity, with eighth nerve vestibular damage or hypersensitivity reactions.

In brief, then, we have considered the three so-called major drugs used in the treatment of tuberculosis, that is, isoniazid, para-aminosalicylic acid and streptomycin. Frequently in the treatment of patients with tuberculosis, circumstances arise in which it would be desirable to use drugs other than the three major ones. Usually these circumstances result from the occurrence of toxic reactions to two or more of the drugs, or from the failure of the major drugs to control the clinical infection. As a rule, clinical deterioration during drug treatment is associated with the emergence of tubercle bacilli which are resistant to the drugs used. In the case of streptomycin, if complete resistance to high concentrations of the drug (that is, 10 to 100 mg/ml) is demonstrated, it probably is futile to continue its use. With PAS and particularly with isoniazid, there is less close correlation between clinical effectiveness and drug susceptibility, as shown by laboratory tests.

In general, cases in which treatment will or should consist of the minor or less frequently used drugs, will be retreatment cases. These are generally patients whose native resistance to tuberculosis is poor, or whose cooperation with treatment is poor and, in general, the prognosis in these cases is not as favorable as it is in the average virgin-treatment case. This must be considered in evaluating the effectiveness of these drugs; however, these minor drugs are so classified because they are either more toxic or less effective from a therapeutic standpoint than are isoniazid, para-aminosalicylic acid and streptomycin.

A listing of the less frequently used drugs would include dihydrostreptomycin, pyrazinamide, cycloserine, viomycin, thioamide, kanamycin, thiocarbanidin, streptovaricin, terramycin, tetracycline, promozole and amithiazone.

*Dihydrostreptomycin* has the same therapeutic effect and complete cross resistance status as

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*Presented before the annual meeting of the Potomac Chapter of the American College of Chest Physicians, at The Greenbrier in White Sulphur Springs, October 9, 1959.

Submitted to the Publication Committee, November 4, 1959.

streptomycin. The only advantage it offers is that it can be used in circumstances in which the need for streptomycin is clearly demonstrated but its use contraindicated because of toxic or hypersensitivity reactions. Dosage of dihydrostreptomycin is the same as for streptomycin. Dihydrostreptomycin should never be used unless the hazard of deafness is acceptable. Deafness may be a delayed reaction to dihydrostreptomycin treatment and may occur after relatively small amounts of the drug have been used. This possibility should be kept in mind when dicrysticin, distrycin, combiotic and similar preparations containing dihydrostreptomycin are used. We feel that its routine use either as a substitute for streptomycin or in combination with streptomycin is to be condemned.

*Terramycin* and the tetracyclines appear to have an effect similar to PAS in delaying the emergence of resistance to streptomycin or isoniazid. This has never proved a popular type of therapy since larger than usual (2 Gm. daily) doses are advised for long periods of time and this rarely is tolerated very well. There is the added risk of monilia and resistant staphylococcal infection. This is also expensive therapy. The tuberculostatic effect of these drugs alone seems to be very slight, if any.

*Amithiazone*, a thio-semi-carbisone drug known as TB-1, or tibione, is chiefly of historical interest. The drug was used between 1949 and 1952, and found to be of high toxicity, low therapeutic effectiveness, and ineffective in delaying the emergence of streptomycin-resistant bacilli. It is chiefly of interest as having stimulated the study which led to isoniazid.

*Promizole* also is of historical interest only, having been one of the first preparations used, although unsuccessfully, with streptomycin in an attempt to suppress streptomycin-resistant organisms.

*Streptovaricin* is an antibiotic obtained from a streptomyces species. It was proposed in 1957 for study but was found to be relatively ineffective in clinical use and has been abandoned.

*Thiocarbanidin* was reported in 1958 as a preparation of low toxicity which was effective *in vitro* against the tubercle bacillus, and preliminary clinical studies suggested that it might be useful *in vivo* for treatment of tuberculosis. When it was tried in tuberculous patients, however, it proved ineffective. Thiocarbanidin is relatively insoluble in water and is absorbed from the gastrointestinal tract in such small amounts that it is of no clinical value.

*Pyrazinamide*, next to isoniazid and streptomycin, is perhaps the most potent drug available for treatment of tuberculosis. It is given orally and is generally well tolerated without producing gastrointestinal symptoms. Pyrazinamide is effective in preventing the emergence of isoniazid-resistant organisms when it is given with isoniazid, and the combination of isoniazid 300 mg. daily and pyrazinamide 3 Gm. daily has proved to be equal in therapeutic effectiveness to the combination of isoniazid and para-aminosalicylic acid. More recent attempts to reduce the dosage of pyrazinamide from 3 Gm. to 1.5 Gm. daily have not been so successful, especially in the far advanced tuberculosis cases. Unfortunately, pyrazinamide is hepatotoxic and has produced evidence of hepatitis in over 10-15 per cent of cases in which it was used for any period of time. This has usually been detected by the occurrence of mild gastrointestinal symptoms associated with abnormal liver function tests such as increased serum transaminase, increased retention of BSP, increased thymol turbidity reaction, and elevation of serum bilirubin. If treatment is stopped promptly at this point, the hepatitis is completely reversible and recovery takes place, with return of the hepatic function to normal. If treatment with pyrazinamide is continued, clinical jaundice will occur and if pyrazinamide is continued in the face of jaundice, death from acute atrophy of the liver may follow. Reducing the dose from 3 to 1.5 Gm. daily apparently has reduced but not eliminated the hepatotoxicity from pyrazinamide. Decreasing the duration of administration will reduce the incidence of toxicity, which may occur at any time during administration of the drug.

Although there are some reports to the contrary, we have not found pyrazinamide effective in delaying the emergence of resistant organisms to drugs other than isoniazid; therefore, pyrazinamide apparently is no more effective in combination with para-aminosalicylic acid, streptomycin, cycloserine or viomycin than when used alone. In the latter case the duration of clinical effect is limited to about six to eight weeks before resistance develops. This makes it a relatively satisfactory drug for use for prophylaxis, for excisional surgery, in cases in which resistance has developed to the other available anti-tuberculosis drugs.

Pyrazinamide alone, then, is a useful drug for short term therapy, or for long term use combined with isoniazid if there is susceptibility of the infecting bacilli to isoniazid; but it is a hazardous drug and should be given only in hospitals or in circumstances where regular and frequent liver function tests and close clinical supervision are possible.

*Cycloserine*, marketed as seromycin, is easily administered, orally, in capsules, and can be given with isoniazid, if isoniazid-susceptible organisms are present. Cycloserine does not appear to be as effective as para-aminosalicylic acid in preventing the emergence of isoniazid-resistant organisms. Cycloserine and isoniazid do not appear to be as effective therapeutically in combination as isoniazid and para-aminosalicylic acid, so that cycloserine is not presently recommended for initial treatment of virgin infections.

In retreatment cases, cycloserine has been combined with pyrazinamide, but we have found that the results are no better when these drugs are used in combination than they are when either is used alone. Cycloserine with viomycin, however, appears to be a more effective drug combination and one which, at present, is the most satisfactory for use in retreatment cases not suitable for treatment with any of the three major drugs. The cycloserine is given in dosage of from 0.5 to 1.0 Gm. daily in divided doses, and the viomycin in dosage of 1.0 Gm. intramuscularly twice a day on two days a week at three to four day intervals.

Cycloserine is a moderately toxic drug, causing reactions such as weakness, twitching, tremor, poor coordination, hyperreflexia, visual disturbances, convulsions, disturbed mental state with nervousness, irritability, somnolence, insomnia, disturbances of memory and concentration; also, visual hallucinations, and paranoid and depressive reactions. Hypersensitivity reactions also occur. Toxicity is proportionate to dosage and usually is not a serious problem when 0.5 Gm. daily dosage is used. Dilantin, phenobarbital, and pyridoxine, as well as meprobamate, are useful in controlling the toxic reactions. We are presently giving dilantin 0.3 Gm. daily, and pyridoxine 100 mg. daily, to all patients receiving cycloserine 1.0 Gm. daily. These drugs should be given from the institution of treatment for prophylaxis of toxicity rather than withheld until toxicity develops.

*Viomycin* has been discussed previously with cycloserine. This antibiotic can be given only by injection and is relatively toxic. Impairment of hearing may develop on doses presently used, so routine audiograms should be made when viomycin is given. Hypersensitivity reactions also occur. The other toxic effects such as electrolyte disturbances, especially hypokalemia, renal disturbances with albuminuria, and eosinophilia are seen less frequently with intermittent dosage than they were with the daily dosage previously used.

*Kanamycin*, available under the trade name Kantrex, is also an antibiotic obtained from a streptomyces species, and one that is effective against a variety of bacteria, including the tubercle bacillus. It is effective against tubercle bacilli resistant to streptomycin, isoniazid, para-aminosalicylic acid and cycloserine, but it is not effective against viomycin-resistant organisms.

When kanamycin was given to patients in dosage of 1.0 Gm. daily, severe deafness developed in a prohibitively high number and was sometimes progressive even after the drug was stopped. We are now trying the dosage of 1.0 Gm. three times a week, but would consider that kanamycin should be used in the treatment of tuberculosis only on an experimental basis in hospitals equipped for clinical research.

*Thioamide*, alphaethyl-thioisonicotinamide, which, like isoniazid, is a derivative of isonicotinic acid, currently is being studied by the Veterans Administration Armed Forces Cooperative Study Group. It is reported to be effective against isoniazid-resistant organisms, and is given orally. The optimal dose has not been clearly established and the drug's effectiveness in combination with other drugs is only beginning to be explored. Pyrazinamide, cycloserine and kanamycin are the companion drugs chosen for the VA studies. The chief toxicity known is gastrointestinal intolerance, which is being studied in relation to dosage. No definite conclusions can be reached regarding this drug as yet. If it should be comparable to streptomycin or isoniazid in therapeutic effectiveness in cases in which tubercle bacilli are isoniazid drug resistant, it might prove to be a valuable preparation for use in retreatment problems.

*Cortisone*. A discussion of drug treatment of tuberculosis probably is not complete without some comment on the use of adrenal steroid drugs. It has been clearly shown that cortisone and related drugs have a deleterious effect on tuberculosis when given alone and, indeed, inactive tuberculosis may reactivate under the influence of long term cortisone therapy.

Because of their suppressive effect on toxicity from tuberculin hypersensitivity, the cortisone type drugs are used in conjunction with the antituberculosis drugs in the treatment of tuberculosis. Usually prednisone, or prednisolone has been the drug selected for steroid effect, although presumably the newer derivatives would be satisfactory. ACTH is sometimes given intermittently with prednisone in an attempt to prevent adrenal atrophy. ACTH alone has the same difficulty as cortisone and hydrocortisone in that the disturbances of glucose and electrolyte functions

are excessive in relation to the anti-inflammatory action.

There is considerable uncertainty about the value of steroid drugs in treatment of tuberculosis. There is no doubt that they promptly suppress the fever and toxemia of acute infection, improve the appetite and clinical well-being, and produce an increased resolution of radiographic signs of pulmonary infection during the early period of treatment. If prednisone is given with an adequate anti-tuberculosis drug treatment program, the combined effect usually is more rapid recovery from severe infections. By four to six months, however, the patients with similar disease treated without steroid drugs have done as well as those treated with steroids, so that the effect is merely suppressive of the infection in the early phase of treatment. Occasionally this suppressive effect has been considered life-saving in desperately ill patients, since there is some lag in obtaining the maximal effect from anti-tuberculosis drugs. Prednisone is effective also in preventing cerebrospinal block in cases of tuberculous meningitis.

The benefit obtained from prednisone must be balanced against the hazards which are inherent in steroid therapy. Disturbances of glucose metabolism and electrolyte balance, increased risk of thrombo-embolic phenomena, of mental disturbance, and of activation of peptic ulcers, with hemorrhage, must be considered. In addition, steroids may obscure complications and may prove actually deleterious in cases in which the tubercle bacilli are resistant to the anti-tuberculosis drugs being given.

**Summary**

In summary, isoniazid, streptomycin and para-aminosalicylic acid are considered the first-line drugs of choice in treatment of tuberculosis. Pyrazinamide can be classed with these three in therapeutic effectiveness, but its general use is limited by the frequency and severity of resultant toxic manifestations. Cycloserine and viomycin are the principal secondary drugs presently available for use. Kanamycin still is under study to determine if an effective dose can be used for an adequate duration of time without incurring deafness. Thioamide will soon be available for study in this country to determine if it will be useful in isoniazid-resistant cases. The other drugs which have been tried have been either too toxic or too weak in their therapeutic effect to be of value for general use.

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# Therapy of Spirit

Modern science is now cognizant of a hate hormone and the physical effects of fear and despair. There is a definite change in the chemistry of the body. But on the positive side the chemistry of despair may be changed to the chemistry of hope and enthusiasm. The hate hormone can be neutralized by the new vitamins of faith and kindliness and a cheerful heart which qualify one's daily existence.

Doctors know that people with a long term illness often seem to die by degrees and if something is lost each day also something may be gained that will throw the balance in the patient's favor.

With more effective control of the long term illnesses communities should enjoy more abundant health. Quantitative extension of the life span which is now taking place may well prove a curse rather than a blessing. Additional years to the life span without corresponding development of the powers of senior citizens so that they may participate in the work of the world and continue as sustaining members of society may threaten the solvency of the nation.

Teen-agers of today and young adults in 25 or 30 years cannot be expected to maintain some 30,000,000 citizens over 60 years of age if the latter are not contributing members of society. Parasitism is a form of social invalidism. For their own benefit and the protection of society the active participation of senior citizens in the working world should be mantained at all costs.—Edward L. Bortz, M. D., in Transactions & Studies, College of Physicians of Philadelphia.

# Special Article

# Bennet Dowler, Clarksburg Physician and Physiologist

*Edward J. Van Liere, M. D., Ph. D.*

PRESUMABLY few, if any, physicians in Clarksburg or in Central West Virginia during the past few decades, or indeed the past century, have been familiar with the name of Bennet Dowler. This is not surprising, since he practiced medicine in that city a long time ago—from 1827 to 1836.

The subject of our essay was born in Elizabeth, Ohio County, Virginia, on April 16, 1797. About all that is known of his early years is that he was educated in Virginia and Pennsylvania. He entered the University of Maryland, and his name appears on the roster of medical graduates for 1827.

It is thought that he began the practice of medicine in Clarksburg, Virginia (now West Virginia) shortly following his graduation from medical school. Interestingly enough, he also served as postmaster there from 1832 to 1836.

Doctor Dowler was a born experimenter, and later became a prolific writer. In 1833, at which time he was practicing in Clarksburg, he published an article in *The Transylvania Journal of Medicine* on the use of calomel in the treatment of cholera. In his early years of practice, he recorded in folios details of all his clinical cases, experiments and ideas. These were used as a storehouse of material which later he employed as occasion arose.

In 1836 Dowler left Clarksburg, and moved to New Orleans for reasons not known. Mayerson writes that he possibly left because he was interested in yellow fever and cholera, since he had treated a few of these cases. We do know that these diseases were prevalent in New Orleans at that time. Another possible factor was that Tulane University School of Medicine had just been founded in New Orleans. Whatever the actual reason was for his leaving Clarksburg, we know that he became engaged in an extensive practice in New Orleans, and further, that he began a long series of physiologic investigations. He became one of the leading citizens of New Orleans and lived there until his death on November 12, 1878.

**Submitted to the Publication Committee, May 16, 1960.**


## *The Author*

- **Edward J. Van Liere, M. D., Dean, West Virginia University School of Medicine, Morgantown, W. Va.**


It is in order to consider some of Dowler's physiologic researches.

### Body Temperature

One of Doctor Dowler's early interests was in body temperature. Shortly after arriving in New Orleans he published two papers which concerned sunstroke. He is recognized as the first investigator to understand the significance of acclimatization to heat. In his writings, he stressed its importance repeatedly. He perceived, also, that the temperature of the body rose when heat loss was inadequate.

Throughout his scientific career he maintained his interest in body temperature. He became intensely interested in the postmortem rise in body temperature, and made many measurements of patients dying of such conditions as cholera, yellow fever, and sunstroke. He found that the postmortem temperature was higher than any maximum it attained during the disease, and wrote a number of articles on his findings.

As Mayerson points out, Dowler was too good a physiologist to overlook the importance of controls. He wished to observe postmortem temperature in people free of disease. As would be expected, he found a solution, namely by obtaining permission to determine body temperature on those unfortunate victims who were hanged in public. He took body temperatures just before and after the people were hanged. This must have been a gruesome business. We can picture him inserting thermometers in different body locations making his readings just before the trap was sprung, and then continuing his researches for some time after death.

He became so much interested in the postmortem rise in body temperature that he advocated it be used as a means of testing for death.

He felt strongly that it was far superior to the use of the stethoscope, and he wrote an article on the subject. It is hardly necessary to state that the method he advocated of determining death was never accepted by the medical profession.

His researches in temperature were indeed widespread. For example, when he traveled on the Mississippi River from New Orleans to Cincinnati to attend the organizational meeting of the American Medical Association, he took temperatures of the water at frequent intervals. He also studied the temperature of fishes.

#### Researches on the Nervous System

When in New Orleans, Dowler made extensive studies on the physiology and anatomy of the alligator. He felt the alligator was higher in the animal scale than frogs, turtles, or salamanders. He wrote, "If frogs are good, alligators are better."

In working with the alligator he sectioned the spinal cord in the cervical and lower thoracic regions, and studied the various reflexes. Later he pithed the spinal cord. Dr. Meek writes, ". . . it is evident Dr. Dowler was studying compound, coordinated reflexes in a spinal-cord-controlled animal. . . . Certainly no American worker had ever before studied these purposive reactions. No one in the whole world had yet noted or written on irradiation in the spinal cord, plurisegmental innervation or inhibition of the reciprocal muscles." Meek emphasizes that Dowler deserves full credit for having first studied reflex action. Unfortunately, however, his interpretations were wrong in that he maintained that the fundamental principle of reflex action is erroneous. In point of fact, he had brilliantly and conclusively shown just the opposite. As Meek aptly states, "If he had only imagined a connection from arcs at one level to those at another level, all his observations would have fallen into order and he would have made for himself at one stroke an enduring name."

#### Independent Irritability of Muscle

Dowler became interested in the postmortem contraction of muscle. Meek points out that the great Swiss physiologist, Albrecht von Haller (1708-1777), the master physiologist of his time, had shown that muscular irritability did not necessarily depend on the central nervous system. This work had been forgotten. It was, of course, Claude Bernard (1813-1878), the famous French physiologist, who proved the independent irritability of muscle by use of curare. It is his work that is remembered.

Dowler naturally was surprised to find that bodies dead for several hours, and in which rigor mortis was beginning to appear, still showed muscular contraction. He observed that a mechanical stimulus, such as a blow from a cane, might cause a contraction of muscle postmortem. He proved to his satisfaction that the assumption by physiologists that the anterior columns of the spinal cord were responsible for all motions could not be true. As Meek writes: "He was consequently led to the conclusion that this contractile force was inherent in muscular tissue and in every portion of it being wholly independent of the brain, spinal cord and nerves. Thus, in the bayous of Louisiana was promulgated the doctrine of the independent irritability of muscle."

#### The Mosquito and Yellow Fever

Due to his interest in comparative physiology, Dowler wrote a detailed account of the natural history of the mosquito. Among other items he discussed its nervous system, muscular force, reproductive power and longevity.

Dowler also wrote voluminously on yellow fever. He railed at the common belief that the disease was due to poor sanitary conditions. In 1859 he wrote in *The New Orleans Medical and Surgical Journal*, "It is reasonable to assume that the fomites of yellow fever, when discovered, will not prove to be either ordinary filth or simply impure air, but some specific, peculiar agent, which produces a specific or peculiar disease—not any disease indifferently, as cholera, intermittent rheumatism, small pox, typhus, etc.," As Mayerson writes, "Here again Dowler narrowly missed his niche in the Hall of Fame by failing to make the connection between the 'peculiar' local agent which he implicated and the mosquito about which he wrote so extensively."

It is a pity that Dowler did not link up yellow fever with the Stegomyia mosquito, but despite his brilliant and imaginative mind he failed to do so. Apparently he was something short of being a genius.

Now that we have considered the principal research areas which interested Dowler, let us turn to other phases of his life.

#### Relations with Professional Physiologists

Dowler had a low opinion of professional physiologists. We have seen that he would not accept the concept that nerve centers controlled peripheral processes which were mediated by the mechanism of the reflex arc. Bell, Magendie and Marshall Hall, all eminent investigators of the physiology of the nervous system, were largely responsible for this concept.

On one occasion he sharply criticized Dunglison, professor of physiology at the University of

Virginia, who had suggested a classification of nerves. Dowler wrote: "This is a fair statement of the existing doctrines of these so-called 'distinguished' physiologists. In what code of morality do 'distinguished' physiologists get a warrant to assert as physical or anatomical facts that which no one has ever seen—no one has ever demonstrated?"

On another occasion he alluded to the experiments they made in these words, ". . . at the expense of the State and by salaried professors . . ." And further, that certain persons derived, ". . . so great a dignity from the state ceremonial as to compensate for their otherwise worthless character—experiments as remote as possible from man and his healthy and morbid conditions."

If Dowler had not been so antagonistic to other scientists, he might have given more careful attention to their views and results. Had he done so, he would in all probability have drawn more accurate conclusions from his own observations. In defense of Dowler's views, however, it must be emphasized that in spite of his busy practice, his writings and his many interests, he still found time for his physiologic researches. He definitely was not an "ivory tower" scientist. It probably was impossible for a man like Dowler to condone the type of life a full time professor lives. At the time Dowler wrote his diatribe the professional physiologist was just appearing on the horizon.

### Editor of Medical Journal

Doctor Dowler served as editor of the *New Orleans Medical and Surgical Journal* from 1854 to 1861, and as editor he was in a position to publish his own scientific articles, and propound his own philosophy. For example, he chided the Montgomery Medical Society for excluding women. He wrote, ". . . there is no sex in science. . . . The question is one of competence not gender."

Editors of medical journals will appreciate the fact that Dowler exhorted his readers first, to pay their subscription, and second, to send in articles for publication. Mayerson points out that he was not too successful in the latter, for Dowler published 12 of his own articles in the 1854 volume of the Journal.

### Dowler Became Nationally Known

Dowler on account of his researches and his prolific writings became not only nationally, but internationally known. For example, he carried on a correspondence with the famous French physiologist, E. Brown-Sequard.

Dowler belonged to a number of scientific organizations, including The Academy of National Science of Philadelphia, The Medico Chirurgical College of Philadelphia, The Medical Society of Virginia, and The Royal Medical Society of Copenhagen.

He was also a fellow and founder of the Society for Northern Antiquities, and a permanent member of the American Medical Association and chairman of its Committee on Medical Science for 1850-1851. He held corresponding memberships in the Society of Statistical Medicine of New York and the Academy of Science of St. Louis.

He is said to have repeatedly refused professorships in various medical colleges, and shunned political office in New Orleans. Obviously he was a man of stature.

### Summary

In summary, we may say that Bennet Dowler was an able scientist with an active and brilliant mind. He was imaginative and had great breadth of interest. He was not only a pioneer physiologist, but a distinguished clinician, and probably was one of the best known citizens of New Orleans. He was a man of restless temperament, and although modesty was not one of his outstanding virtues, he nevertheless had many friends and was highly regarded by his fellow human-beings. He was a man who would have made his mark in any generation. His history, although he failed to achieve first rank in scientific stature, is one of great effort, and, in certain areas, of real accomplishment.

### Author's Note

In this essay I have drawn freely on the following: Meek, W. J., "Bennet Dowler, A Forgotten Physiologist," Annals of Med. Hist. 10:237, 1938; and Mayerson, H. S. "Bennet Dowler," The Physiologist, 3:39, 1960.

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*. . . it is magnificent to grow old, if one keeps young.*

Harry Emerson Fosdick.

# The President's Page

## Cost of Medical Care

THE cost of medical care seems to be such a timely subject with politicians, the press and the public, that I wonder if physicians should not become more aware of the problems that confront us in providing the proper answers to questions that may arise.

When we see titles of articles in magazines such as "Why Doctors Charge So Much and What Can Be Done About It," or when a politician writes, "We've Got to Regulate Doctor's Fees," we remember what John F. Allen said in an article published in the December, 1959, issue of *California Medicine* under the heading, "How the Medical Profession Looks to the Layman": "No matter what it thinks of the brave new world that looms ahead, no matter how it may despise undeniable trends toward social living, organized medicine is doomed to a future of Federal control unless it chooses to lead instead of dragging its heels." We know our patients read these articles with much more than passing interest, so it is our duty to become better informed about the broad subject of the cost of medical care.

Here are some facts which I believe will be of interest to all the members of the medical profession: Even though the public expenditure for medical care in the United States increased from $7.7 billion in 1948 to $16.3 billion in 1958, the actual percentage of cost remains about the same. In 1938 the public spent 4.7 per cent of its disposable income after taxes for medical care, including fees for physicians and dentists, hospital charges, and amounts paid for drugs. Today, it can be shown that 4.6 per cent of the same disposable income goes for medical care even though the cost of living continues to rise. To look at it another way, since 1948, with ever-mounting costs, private hospital care has increased 166 per cent and drugs 122 per cent, while fees of physicians have increased but 67 per cent.

We might conclude that our fees are not out of line, but unfortunately there are a few instances where in my opinion fees of physicians have been excessive, and it is these isolated cases that give rise to the indictment of the entire profession for "putting a high price tag on pain" or "operating on too many people needlessly because of the fees involved."

When I hear some of my colleagues speak of their thirty to fifty thousand dollar a year net income, I feel compelled to analyze a serious situation. In the first place there are but a limited number of working hours in each day; therefore, only a limited number of patients can be seen. Certainly there is a limit to the amount that some patients are financially able to pay, with or without an insurance program.

There are only a few physicians in the so-called "high income bracket," but it is this group that serves the political vote getters well when they are trying to promote some Federal scheme to meet the cost of medical care for our aged and aging. They serve the feature writers on medical topics interesting material for lay readers.

To conclude, let's take a realistic view of a serious situation and set about doing our part in providing satisfactory answers to these problems. Let's be leaders and not drag our heels!

J. C. Huffman, M. D., President

# THE WEST VIRGINIA MEDICAL JOURNAL

*Official Organ of the West Virginia State Medical Association*

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.



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*Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.*

*Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.*


# EDITORIALS

## ARDEN HOUSE CONFERENCE

A group of Medical and Public Health consultants met at Arden House, Harriman, New York, in November 1959, to consider a long range plan for the eradication of tuberculosis. From their discussions there has developed a new goal, technique and eleven recommendations that have come to be known as the Arden House Conference. These specialists were concerned with the inadequate case finding, sporadic treatment, slow but progressive development of resistant strains of tubercle bacilli and failure to find new potent drugs. They felt that now was the time, through new methods and intensification and reworking of the old procedures, to really make the grand effort to eliminate tuberculosis.

"The major recommendation of the Conference is a program for the widespread application of chemotherapy as a public health measure for the elimination of tuberculosis in the United States:

*Goal:* To sterilize that important part of the reservoir of tubercle bacilli that presently exists throughout the country in persons currently suffering from active tuberculous disease, whether presently known or unknown to public health authorities, and in selected persons who previously have had active disease and were inadequately treated.

*Technique:* Mobilize all resources for a widespread application of the scientifically demonstrated and medically accepted procedures of adequate chemotherapy. These include the proper dosage of appropriate drugs or combination of drugs given continuously over an adequate period of time—procedures that are known to destroy tubercle bacilli in the human body, render the patient's disease noncommunicable to others, and minimize the possibility of reactivation.

The unique aspect of this recommendation lies in its emphasis on such chemotherapy primarily as a public health tuberculosis control measure (as well as for the benefit of the individual patient) with all of the connotations of community mobilization and control by public health authorities that this new concept implies. This recommendation obviously implies as well an adequate case detection program."

The eleven recommendations concern the general procedures designed to implement the major recommendation. Through these activities our present methods of control may be strengthened, and by application of more refined measures we may achieve the actual eradication of the disease.

A study of the conference procedures suggests many new ideas. They detail many procedures now in operation in limited surveys. Methods that will help to attain this goal include treatment of all tuberculin reactors under a specified age,

treatment of all recent convertors, and treatment of all contacts.

Physicians will not find fault with the goal devised by the conference. Of course, any project of such magnitude will not be accepted in toto without prolonged instruction and discussion. Enthusiasm supported by skillful trained effort and personnel give the aims of the conference great substance.

During the past ten years it has been demonstrated that there are better techniques for the treatment of tuberculosis. We now know that prolonged and complete rest is not necessary for the arrest of tuberculosis, that the use of special therapies such as pneumotherapy is a thing of the past, and that institutional treatment is necessary during the communicable stage and for the prolonged treatment of medical problem cases. The treatment of tuberculosis has become increasingly the responsibility of the practicing physician. Sanatoria throughout the land have found their patient population constantly decreasing, so it is doubtful if the medical profession will completely embrace the proposition that the treatment of tuberculosis is primarily a public health procedure.

The West Virginia Tuberculosis and Health Association at its Spring Meeting in 1960 discussed the recommendations of the Arden House Conference and asked the Tuberculosis Committee of the West Virginia State Medical Association for guidance in applying the recommendations to the tuberculosis problem in this state.

One change of policy that could immediately implement the aims of this conference is the removal of the barbaric regulation which denies free drugs to the needy tuberculous because they are AWOL or have left the sanitarium against medical advice. This ruling does not diminish the rate of unapproved discharges. It does promote interruption of treatment, increases instability of disease, drives the tuberculous underground and increases the inherent dangers of tuberculosis to the individual and the community.

The indigent tuberculous patient in the home is in greater need of free drugs than the sanitarium patient. It is doubtful if the legislature planned to restrict the distribution of the drugs when it made an appropriation for free medication. Medical needs must not be hampered by such restrictive regulations.

The complete story of the Arden House Conference is available through local Tuberculosis Associations.

## BENNET DOWLER, PHYSICIAN AND PHYSIOLOGIST

Elsewhere in this issue will be found an article, "Bennet Dowler, Clarksburg Physician and Physiologist." It is of historical and cultural interest that an eminent physiologist and physician practiced in one of the important cities of our state. Not only did Doctor Dowler have a busy practice, but he served also as postmaster for four years. At the time he lived in Clarksburg (1827-1836) the population was small, so his duties as postmaster probably did not interfere with his medical practice.

Clarksburg has had, and indeed still has, a number of outstanding physicians, some of whom have been leaders in the medical profession in our state. It is to be hoped that a historically-minded person, preferably a physician, will some day write about early medical practice in this centrally located city.

In this connection, several thoughts come to mind, such as the practice of medicine during the War between the States, and also the Spanish-American War. In more recent years, the distinguished cardiologist, Paul Dudley White, has mentioned that the first postgraduate work he ever gave (outside of Boston) was in Clarksburg.

Another thought, albeit it does not bear any relation to the practice of medicine in Clarksburg, is that the eminent J. A. E. Eyster, professor emeritus of physiology at the University of Wisconsin, worked when a young man with a surveying crew one summer in the area around Clarksburg. These two widely divergent examples emphasize the possibilities of material for research in the history of medicine in Clarksburg and its immediate vicinity.

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## THE HUNTINGTON CLINICAL FOUNDATION

This organization was set up by the late Mr. Rufus Switzer, a former Mayor of Huntington, an outstanding native son of Cabell County, and one of the most prominent attorneys of early Huntington. His objective was to build better health in Cabell County. The trustees were directed to spend the income of the Foundation for "the study and treatment of disease, and for the betterment of health in Cabell County." Mr. Switzer, in his lifetime, discussed with some of the present trustees his ideas of what might be accomplished through his bequest and made it clear that the trustees were to construe broadly the words "health" and "disease."

Considering the needs of medical and nursing education, the trustees have adopted a plan to

lend $2,000 a year to a minimum of two needy medical students annually and a maximum of $1,000 annually to needy pupils in each of the two Huntington Training Schools for Nurses. The details have not yet been entirely worked out, but it is hoped that the plan can be put into operation the coming scholastic year. One definite requirement of the medical student borrower will be a contract to intern in a Huntington hospital recognized by the Hospital Accreditation Commission for intern training. Borrowers must be citizens of West Virginia or of other states within a radius of 150 miles from Huntington. Applicants for loans should address: Lawrence B. Gang, M. D., Chairman, 1016 Sixth Avenue, Huntington, West Virginia.

As soon as details are completed, a report will be sent to all medical schools in this area, the medical journals of adjacent states, and the press.

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**WELCOME, MISSISSIPPI**

We are much pleased with the new *Journal of the Mississippi State Medical Association* which succeeds *The Mississippi Doctor*, a private enterprise. The former editor of the old magazine, Dr. William H. Anderson, is the editor of the new State Journal. The managing editor is Mr. Rowland Kennedy, the Executive Secretary of the Mississippi State Medical Association.

The appearance of this newcomer into the fold of state medical journals is pleasing to the editorial eye. The format is excellent, and the scientific content certainly well up to the standards of the older state journals. Probably its most outstanding scientific facet is the Clinical Pathological Conference which has so far been presented in each issue. This feature stems from the University of Mississippi Medical School which, though young, is evidently a top-notch institution as is demonstrated by the fact that none of its graduates flunked a state board last year.

We are glad to welcome The Mississippi Journal, not as a fledgling, for that is not the case. As the azure-eyed Minerva sprang full-fledged from the brain of Jove, so has *The Journal of the Mississippi State Medical Association* sprung full-fledged into our midst.

Again welcome; doubly welcome.

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### The One That Got Away!

Liars are never specific. You even believe a fisherman when he announces the length of his fish in feet and inches. You smile only when he measures his catch with a gesture.—James R. Adams.

### Watch Out!

It is quite possible the powers that be in Washington have more than one reason for complaining about the prices of drugs. Senator Estes Kefauver's drug price investigating subcommittee would have us believe that the government's sole interest is "simply with the price of drugs—a price which must be paid by someone under any system of medical care." I think there is a psychological reason which they hope to keep under cover. This Senate antitrust investigation is just another cunning approach in the attempt to slip socialized medicine in at the back door. It appears to me that Mr. Kefauver almost gave this fact away in his opening statement when he said: "It is not the purpose of these hearings to question in any way the American system of private medical practice." I react to this statement in the same manner I would if a small boy should rush into my office and exclaim: "Doctor, someone batted a baseball through your back window—and I don't want you to think that I did it."

If these investigators' thoughts were just in the drug field, they should also be concerned about quality as well as price. They certianly have shown a lack of interest in the cost of pharmaceutical research and manufacturing, and without research drugs would soon degrade in both quality and quantity. The Senator's line of reasoning in advocating that druggists be allowed to use generic instead of brand names, would throw the drug business into a tail spin within a short time. If one company spends a million dollars to produce a new drug, and another concern is allowed to copy the formula, pay none of the research cost, and market the product at a low price, the results would be disastrous. The better firms would go broke, initiative to find new drugs would be smothered and we would find ourselves advancing in reverse—back towards the "calomel and castor oil days."

I feel that these governmental probes are motivated, primarily, for publicity. If they can attract enough attention by their investigations of the major drug manufacturing firms, and lead the American people into believing that the prices of drugs are too high, it might be possible to gain a large number of sympathetic listeners.

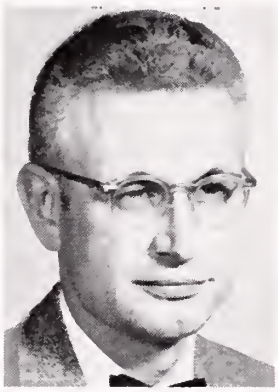
People, consciously, or unconsciously, associate drugs and physicians together. An aroused populace against drug prices would not be too friendly towards the medical profession. Such a situation would gain recruits for a more effective battle against the free practice of medicine. While we sit on the side lines, apparently unmolested, and watch the steam roller attempt to crush the drug firms, we must remain alert. We could get caught napping like Hitler did one time during World War II—when Allied soldiers were issued heavy, long-handled underwear. As soon as the Germans got wind of it, they rushed up to Norway while our troops poured into Africa. It behooves us to watch out for all sorts of misleading tactics, because this drug battle is only a sham attack. The medical profession is their chief objective.—F. Clyde Bedsaul, M. D., in Virginia Medical Monthly.

# GENERAL NEWS

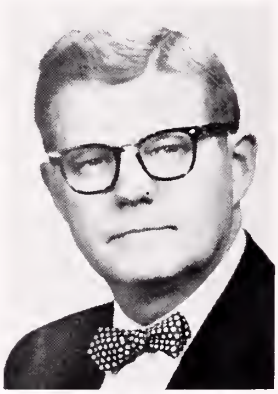
## Program Completed for Annual Meeting At The Greenbrier, Aug. 25-27

The program has been completed for the three general scientific sessions which will be held during the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

Dr. Seigle W. Parks of Fairmont, chairman of the Program Committee, announced that the program on



Bernard Zimmermann, M. D.



Herbert E. Warden, M. D.

Friday morning, August 26, will be presented by members of the faculty of the new four-year School of Medicine at West Virginia University.

President Elvis J. Stahr, Jr. will open the program with an address on the subject of "Your University." He will be followed by Dr. Kenneth E. Penrod, Vice President-Medical Affairs, whose subject will be "A Medical Center for the 60's."

Dr. Edmund B. Flink, Professor and Chairman of the Department of Medicine, and Dr. Bernard Zimmermann, Professor and Chairman of the Department of Surgery, will discuss "The Medical and Surgical Aspects of Hyperadrenalism."

Dr. Herbert E. Warden, Associate Professor of Surgery, will close the morning program with an address on the subject of "Cardiac Aneurysms: Diagnosis and Surgical Treatment."

### Thursday Morning Program

The program for the other two general scientific sessions has also been completed. The scientific program at the first general session on Thursday morning, August 25, will be in the nature of a "Symposium on Pyelonephritis."

The panel will be composed of Thomas A. Stamey, M. D., Associate Professor of Urology, The Johns Hopkins University School of Medicine, Baltimore; John B. Hazard, M. D., Chairman of the Division of Pathology and Head of the Department, Cleveland Clinic Foundation, Cleveland, Ohio; and George A. Wolf, Jr., M. D., Dean and Professor of Clinical Medicine, University of Vermont College of Medicine, Burlington, Vermont.

### Saturday Morning Session

The third and final general session will be held on Saturday morning, August 27, and the following program presented:

"Pediatric Gynecology."—Roger B. Scott, M. D., Associate Professor of Obstetrics and Gynecology, Western Reserve University School of Medicine, Cleveland, Ohio.

"Anesthesia in the Complications of Pregnancy." —Vincent J. Collins, M. D., Associate Professor of Anesthesiology, New York University Medical Center, New York City.

"Problems of Adolescence."—Edward M. Litin, M. D., Consultant, Section of Psychiatry, Mayo Clinic, Rochester, Minnesota.

### Afternoon Meetings

Meetings of the Association's sections and affiliated societies and associations will be held afternoons during the three-day meeting. Several of the guest speakers will also present papers before these groups.

### Honor Guests on Program

One of the honor guests at the meeting, Dr. Charles B. Jolliffe, will be the first speaker on the Thursday morning program. Doctor Jolliffe, a native of Mannington, West Virginia, and a graduate of West Virginia University, is Vice President and Technical Director of the Radio Corporation of America.

Another honor guest will be Dr. E. Vincent Askey of Los Angeles, California, who was installed as President of the American Medical Association at the annual meeting in Miami Beach last month. He will deliver an address before the second session of the House of Delegates on Saturday afternoon, August 27.

Dr. J. C. Huffman of Buckhannon, President of the State Medical Association, will deliver his presidential address at the first session of the House of Delegates on Wednesday evening, August 24.

### Entertainment Features

Entertainment features during the meeting will include a dance in the Main Ballroom on Friday evening, August 26, sponsored by the Woman's Auxiliary, and a cocktail party and reception honoring officers of

the State Medical Association on Saturday evening, August 27.

In addition to Doctor Parks, the other members of the Program Committee are Drs. Theresa O. Snaith of Weston, G. Thomas Evans of Fairmont, and William A. Thornhill, Jr., and Kenneth G. MacDonald of Charleston.

**Heavy Advance Registration**

The number of reservations for rooms at The Greenbrier during the annual meeting in August has passed the 500 mark and it is anticipated that more than 850 persons, including physicians, their wives and guests, will be in attendance.

All physicians who plan to attend the meeting are urged to make reservations as soon as possible. An early request will assure physicians, their families and guests of room accommodations.

The complete program for the meeting will appear in the August issue of *The West Virginia Medical Journal.*

### No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 93rd annual meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27, 1960.

A cordial invitation to attend all sessions has been extended by the Program Committee to interns and physicians serving a residency in hospitals in West Virginia and adjacent states.

Requests for hotel accommodations should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs.

## Dr. Frank V. Langfitt Honored By Salem College

Dr. Frank V. Langfitt of Clarksburg has been given the honorary degree of Doctor of Humanities by Salem College. The award was made during commencement exercises on the college campus late in May.

Doctor Langfitt, a native of Doddridge County, is a past president of the Harrison County Medical Society and the West Virginia State Medical Association. He received his academic education at Salem College, West Virginia Wesleyan and West Virginia University.

He received his M. D. degree from the University of Maryland School of Medicine and had postgraduate work at the Mayo Clinic and Johns Hopkins.

## Summer Camp for Asthmatic Children

A summer camp for asthmatic children, sponsored by the Betty Bacharach Home, is in operation this year at Longport, New Jersey. Children from five to twelve years of age are eligible to attend the camp which will remain open until September 4.

Further information may be obtained by writing to Martin Green, M. D., Pediatric Allergist, Betty Bacharach Home, Longport, New Jersey.

## New Rules for Golf Tournament During 1960 Convention

Dr. Joseph T. Mallamo of Fairmont, Chairman of the State Medical Association's Golf Committee, has announced rules and regulations that will apply during the Annual Medical Golf Tournament which will be held in connection with the 93rd Annual Meeting at The Greenbrier, White Sulphur Springs, August 25-27.

Doctor Mallamo and the other members of his Committee, Drs. Robert S. Wilson of Clarksburg and George A. Curry of Morgantown, have decided upon a radical change in the time of official tournament play. Instead of play being restricted to afternoons, as in the past, participants may engage in tournament play both mornings and afternoons during the Annual Meeting.

Those who participate will pay an entrance fee of $5, payable at the time they register for play in the tournament. There will be several prizes, including the award of the grand championship trophy.

The tournament will be set up in different flights, according to the number of players. For example, if there are 90 players, then there will be approximately six flights, with a low gross and a low net prize for each flight.

The Chairman, Doctor Mallamo, won a second leg on the championship trophy in 1959. The trophy is offered by the Hospital and Physicians Supply Company of Charleston.

## Merger of Charleston and Huntington Blue Cross Plans Completed

Mr. William T. O'Farrell, Charleston attorney, has been elected president of Blue Cross Hospital Service, Inc., including merged Blue Cross plans of both Huntington and Charleston. The merger of the two plans was completed at a meeting held in Charleston on June 6. There are more than 100,000 policy holders in the combined plan.

Mr. Ohley L. Davis of Huntington was named vice president, Mr. Virgil W. O'Dell of Charleston, treasurer, and Miss Virginia Kahle, also of Charleston, secretary.

Mr. John Hart was named managing director of the new plan. He has served as manager of Medical Service, Inc., of Charleston, for the past several years.

Offices of the Plan will be maintained in both Charleston and Huntington. The merger does not affect Blue Shield plans currently operating in each city.

A twenty-five member board of directors has been named, 15 from Charleston and 10 from Huntington. The members, in addition to those holding major offices, are as follows:

Charleston: A. C. Weaver, Robert Witschey, Charles Warner, Charles Showalter, Col. Ben W. Venable, Dr. H. M. Beddow, William Male, Dr. Milton J. Lilly, Jr., George Mattix, Eugene Groves, and Dr. A. J. Magee.

Huntington: E. H. Cline, Hugh D. Stillman, J. B. Meek, Phillip A. Baer, John H. Christian, J. Hanley Morgan, Laurel F. May, Richard E. Tyson and Harold R. Hastings.

## Dr. Edmund B. Flink Named Chairman Of WVU Department of Medicine

Dr. Edmund B. Flink of Minneapolis, Minnesota, has been appointed Professor and Chairman of the Department of Medicine at the West Virginia University School of Medicine. He will assume his duties at the Medical Center this summer.

Doctor Flink has been serving as professor in the Department of Medicine at the University of Minnesota

Edmund B. Flink, M. D.

Medical School, where he has been a member of the staff since 1942. He also served as chief of medical services at the Veterans Administration Hospital in Minneapolis.

He is recognized as an authority in the field of endocrinology and metabolic diseases and has published more than 70 articles in professional journals.

The appointment of Doctor Flink was announced late in May by University President Elvis J. Stahr, Jr. Another staff member of the University of Minnesota Medical School, Dr. Bernard Zimmermann, several months ago accepted appointment as Professor and Chairman of the Department of Surgery at the new four-year School of Medicine.

In a joint statement concerning the appointment, President Stahr and Dr. Kenneth E. Penrod, Vice President-Medical Affairs, said "we are truly delighted that Dr. Edmund B. Flink has accepted this challenging position, which is of key importance to West Virginia's new Medical Center. We are confident that the team of Doctor Flink and Doctor Zimmermann will help West Virginia build one of the nation's truly great medical schools. For several years they have worked together in a highly productive manner, so in a very real sense, we have obtained a team at the outset."

Both Doctor Flink and Doctor Zimmermann will appear as guest speakers on the scientific program during the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in August.

### Native of Minnesota

Doctor Flink is a native of Minnesota and attended the public schools at Cambridge in that state. He was graduated from the University of Minnesota and received his M. D. degree from the Medical School of that University in 1938. Following an internship at the University of Minnesota Hospitals, he was awarded a four-year teaching fellowship at the Medical School. He received his Ph. D. degree in 1945.

He was appointed an instructor in the Department of Medicine of the University of Minnesota Medical School in 1942; assistant professor, 1943; associate professor, 1950; and professor, 1957.

He spent one year, 1948-49, as a research fellow in the Department of Biochemistry at Harvard Medical School, and as clinical assistant, medical service, at Peter Bent Brigham Hospital in Boston. In 1957-58, he served as a visiting professor at Seoul National University in Korea.

Doctor Flink was certified by the American Board of Internal Medicine in 1945. He is a Fellow of the American College of Physicians and a member of the Minnesota State Medical Association and the AMA. He is married and the father of four children.

## Medical Meetings, 1960

The following is a partial list of national, state and district medical meetings scheduled for 1960:

July 11-13—Medical Licensing Board, Charleston.
**Aug. 25-27—93rd Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.**
Sept. 13-15—National Cancer Conf., Minneapolis.
Sept. 16—W. Va. Heart. Assn., Parkersburg.
Sept. 22-24—W. Va. Hospital Assn., White Sul. Springs.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 9-14—Am. Acad. Oph. and Otol., Chicago.
Oct. 10-14—ACS, San Francisco.
Oct. 17-20—Am. Acad. Pediatrics, Chicago.
Oct. 21-23—PG Institute, Martinsburg.
Oct. 21-25—Am. Heart Assn., St. Louis.
Oct. 31-Nov. 3—Southern Medical, St. Louis.
Nov. 29-Dec. 2—AMA Clinical Meeting, Washington, D. C.

## ACP Plans Regional Meeting In Pittsburgh, Feb. 2-3

A combined meeting of the American College of Physicians for Ohio, Western Pennsylvania and West Virginia will be held in Pittsburgh, February 2-3, 1961.

Dr. Robert U. Drinkard of Wheeling, ACP Governor for West Virginia, has written to all the members stating that it is highly desirable that West Virginia be well represented with papers on the program for this regional meeting. Titles and abstracts should be ready by October 1, 1960. Full information concerning the forthcoming meeting may be obtained by writing to Doctor Drinkard, Central Union Building, Wheeling, West Virginia.

## State Medical's 'Speech Award' Won By Miss Linda Ann Long

Miss Linda Ann Long, a sophomore at Morgantown High School, was the winner of the West Virginia State Medical Association's Speech Award of $25 for the best paper on a medical subject submitted by a member of the West Virginia Junior Academy of Science during the school year, 1959-60. Her subject was "Hypothermia."

Miss Long's selection as the winner of the award was announced during the annual meeting of the Junior Academy at Concord College in Athens late in April.

The award, offered annually by the State Medical Association, was won last year by Mr. Walter R. T. Witschey of Charleston High School, who presented a paper on the subject of "Experimental Ultra-Centrifuges." The winner for the school year 1957-58 was Miss Karen Jordan of Sutton High School. Her subject was "Heredity."

Dr. Herald D. Bennett, of the biology department of West Virginia University, has been named president elect of the Junior Academy and Mr. Robert L. Birch, also of the department of biology, is the new treasurer.

Miss Iris M. McClure, a member of the faculty of Morgantown High School, continues as coordinator of the Junior and Senior Academies of Science.

## Mrs. Ethel Keller Installed as Head Of State Medical Assistants

Mrs. Ethel Keller of Parkersburg was installed as president of the West Virginia Association of Medical Assistants at the annual meeting held at Blackwater Falls Lodge, near Davis, May 21-22, 1960.

Mrs. Mary E. Kessler of Beckley was named president-elect; Mrs. Leona Grow of Parkersburg, vice president; Miss Genevieve Hopkins of Parkersburg, secretary; and Mrs. Wayne Higginbotham of Charleston, treasurer.

Delegates to the Annual Meeting of the American Association of Medical Assistants, which will be held in Dallas, Texas in October were named as follows: Mrs. Ethel Keller and Mrs. Carol Keller, both of Parkersburg, and Miss Jane Truman of Charleston. Alternates are Mrs. Miller Hanley of Charleston, Mrs. Wallace Byrd of South Charleston, and Mrs. Noble Hicks of St. Albans.

Mrs. Hicks was elected to a three-year term as a member of the board of directors.

Dr. J. C. Huffman of Buckhannon, president of the West Virginia State Medical Association, was the guest speaker at the session held on Sunday morning. He presented an interesting and informative address on the subject of "Medical Ethics."

One of the highlights of the meeting was a presentation of the charter by Mrs. Lucille Swearingen of Bartlettsville, Oklahoma, immediate past president of the national organization. A gavel was presented to the group by the members of the Parkersburg Chapter.

The 1961 meeting of the Association will be held in Parkersburg.

## Dr. Emma J. Freeman Heads Division Of Maternal and Child Health

Dr. Emma Jane Freeman of Buckhannon has been appointed Director of the Division of Maternal and Child Health of the State Department of Health. The appointment was announced early in June by Dr. N. H. Dyer, State Director of Health.

Emma Jane Freeman, M. D.

Doctor Freeman, who succeeds Dr. Theodore H. Boysen, III, who resigned late in May to engage in private practice outside of West Virginia, will assume her new duties in Charleston on July 1.

Born at Adrian in Upshur County, Doctor Freeman graduated from Buckhannon-Upshur High School. She received her A. B. degree from West Virginia University in 1947 and her B. S. degree there in 1949.

She graduated from the Medical College of Virginia in 1951 and was licensed to practice medicine in Virginia that same year. She served her internship at the Medical College of Virginia Hospitals, 1951-52, and was an assistant resident in pediatrics, 1952-53, and a resident in that specialty, 1953-54. During the time she served her residencies, she worked in well child conferences conducted by the State Health Department in Richmond.

Doctor Freeman was licensed to practice in West Virginia in July, 1954, and has engaged in the practice of her specialty of pediatrics in Buckhannon since that time. She has served as a part-time health officer for Upshur County since January, 1959.

She is a member of the Central West Virginia Medical Society, the West Virginia State Medical Association and the American Medical Association, and has served as secretary-treasurer of her local society for the past three years.

## Dr. Charles A. Hoffman Named Member Of Blue Shield Plans Committee

Dr. Charles A. Hoffman of Huntington has been named a member of the Professional Relations Committee of the national Blue Shield Medical Care Plans for the coming year. The appointment was announced recently by John W. Castellucci of Chicago, executive vice president.

Dr. Russell B. Carson of Fort Lauderdale, Florida, is chairman of the committee and the other members are Dr. Paul A. Clayton, Salt Lake City, Utah; Dr. Ira Layton, Kansas City, Missouri; and Mr. Tom Reed, Boston, Massachusetts.

Doctor Hoffman is a past president of the West Virginia State Medical Association and is currently serving as chairman of the Insurance Committee.

## State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected since January 1, 1960:

**Barbour-Randolph-Tucker**

| | |
|---|---|
| Blackburn, Bill Robert | Elkins |
| Glenn, John Hubert | " |
| Ingram, Marion E. | Buckhannon |
| Sudranski, Herbert F. | Elkins |

**Boone**

| | |
|---|---|
| Greever, Carl J. | Whitesville |
| McCoy, Edwin R. | Seth |

**Cabell**

| | |
|---|---|
| Cserny, Edith | Huntington |
| Dransfeld, Hans Werner | " |
| Ripley, Gary L. | " |
| Sheppe, Jack O. | " |
| Vaziri, Hassan | Milton |

**Eastern Panhandle**

| | |
|---|---|
| Nichols, S. I. | Berkeley Spgs. |

**Greenbrier Valley**

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|---|---|
| Shreve, Don F. | White Sulphur Spgs. |

**Hancock**

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|---|---|
| Gretchen, Edward A. | Weirton |

**Harrison**

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|---|---|
| Biddle, Benjamin H. | Nutter Fort |
| Gerwig, Walter H. | Clarksburg |

**Kanawha**

| | |
|---|---|
| Billingsley, John A. | Widen |
| Cleary, Robert V. | So. Charleston |
| Young, Bascom B. | Charleston |
| Van Winkle, Glen F. | Belle |

**Marshall**

| | |
|---|---|
| Allen, Kenneth J., Jr. | Moundsville |

**Mason**

| | |
|---|---|
| Jones, Anna C. | Lakin |
| Rainbow, Kathryn A. | " |
| Roush, Wm. Harold | Pt. Pleasant |
| Telle, Lewis Donald | " |

**McDowell**

| | |
|---|---|
| Skewes, David J. | Coalwood |

**Mercer**

| | |
|---|---|
| Bryan, John J. | Bluefield |
| Haynes, Ralph E. | " |
| Neilson, Robert W., Jr. | " |

**Mingo**

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|---|---|
| Duley, Norman Douglas | Williamson |

**Monongalia**

| | |
|---|---|
| Cather, Carl H., Jr. | Morgantown |
| McKeehan, Frederick R. | " |
| Provins, Austin A. | " |
| Young, Harold G. | " |

**Ohio**

| | |
|---|---|
| Aceto, Joseph Nicholas | Wheeling |
| Howland, Willard J., Jr. | " |
| Hudson, Frank M. | " |
| Jacob, James A. | " |
| Nesper, Thomas E. | " |

**Parkersburg Academy**

| | |
|---|---|
| McDougal, Robert A. | Parkersburg |
| Thacker, Charles W. | " |

**Potomac Valley**

| | |
|---|---|
| Bess, Robert W., Jr. | Piedmont |
| Harman, Chester D. | Petersburg |
| Pasquale, Andrew Jim | " |

**Preston**

| | |
|---|---|
| Wolverton, Wm. R. | Kingwood |

**Raleigh**

| | |
|---|---|
| Anderson, Ira Braxton | Beckley |
| Beam, Curtis E. | " |
| Artman, Ralph T. | " |
| Glenn, James H. | " |
| Griffey, Walter P. | " |
| Schneider, Edward M. | " |

**Wyoming**

| | |
|---|---|
| Rheney, Theodore B. | Oceana |

## Dr. William P. Bittinger Honored By Public Health Assn.

Dr. William P. Bittinger of Summerlee, Fayette County, was honored recently by the West Virginia Public Health Association for meritorious contributions to the field of public health in the state.

Doctor Bittinger received the award at a banquet held in connection with the 36th Annual Meeting of the Association in Bluefield, May 11-13. Presentation of the award was made by Dr. N. H. Dyer, State Director of Health.

Doctor Bittinger, who has served as a member of the Medical Licensing Board since 1939, has been active in the field of public health for many years. He is a past president of the West Virginia Tuberculosis and Health Association and the Fayette County Medical Society. He served for several years as a director of the National Tuberculosis Association. He is currently serving as a member of the Legislative and Tuberculosis Committees of the West Virginia State Medical Association.

Another award was presented to Mrs. Wayne Gadd of Princeton, executive secretary of the Mercer County Tuberculosis and Health Association, who received the Citizens Award for "furthering public health activities."

The awards are presented annually by the Association to a layman and a professional person for outstanding work in the field of public health in West Virginia.

Dr. B. S. Brake, Health Officer of the Harrison-Clarksburg Health Department, was elected president of the Association for the coming year. He succeeds Mr. Eugene J. Powell of Charleston, Administrative Assistant to the Director of Disease Control, State Department of Health.

Mrs. Eva B. Green of Huntington was named president elect; Mrs. Wanda Johnson of Charleston, first vice president; James Rosencrance of Charleston, second vice president; and Anne Rouse of Charleston, treasurer.

Elected Members-at-Large to the Executive Council were Harry K. Gidley, consulting engineer of Charleston; J. B. Baker, Harrison-Clarksburg Health Department; and J. Roy Monroy of South Charleston.

Drs. L. A. Dickerson of Charleston and Bruce H. Pollock of Huntington were named as the Association's delegates to the American Public Health Association.

## Mental Health Workers Receive SREB In-Service Grants

The Southern Regional Education Board has awarded to West Virginia Mental Health personnel three in-service training grants totaling $1,215. The awards were made by the Board under its program in mental health training and research.

The grants were made to Dr. Michael M. C. Young, physician at the Weston State Hospital; Dr. E. M. da-Silva, staff physician at Huntington State Hospital; and Miss Leticia Cartes, attendant at that institution.

The grants made brings to 27 the number of SREB grants that have been awarded to West Virginia Mental Health employees under the program.

The SREB in-service training grants were made possible by a $90,000 grant for this purpose by the National Institute of Mental Health. They are designed to enable staff members of mental hospitals or training schools in the South to observe new or unusual programs in other hospitals anywhere in the country to help them improve their own programs.

Applications for grants are still being accepted by SREB. There is no deadline and applications are acted upon as they are received. Persons interested in the grants should write to Southern Regional Education Board, 130 Sixth Street, N. W., Atlanta, Georgia.

### Catalogue of Medical Health Films

A revised list of films available from the Motion Picture Library of the American Medical Association has been prepared and copies are available upon request. The catalogue lists 175 medical films suitable for showings before medical society meetings, hospital staff meetings and other scientific groups.

In addition, there are 81 health films of interest to physicians who may be called upon to speak before lay groups. Copies may be obtained by writing to the AMA Department of Medical Motion Pictures and Television, 535 North Dearborn Street, Chicago 10, Illinois.

## Additional Staff Appointments Made At WVU Teaching Hospital

Miss Audrey Windemuth, Director of Nursing Service at the West Virginia University Teaching Hospital, has announced the appointment of two additional staff members. They are Miss Elizabeth Skaggs, Nursing Supervisor of the Out-Patient Department and Mrs. Mae Weese Hart, Supervisor of Central Supply Service.

Miss Windemuth also stated that all key supervisory personnel have now been appointed with the exception of the operating room supervisor.

Miss Skaggs was graduated from Vanderbilt University with a degree in public health nursing and clinical teaching. She also attended Blackstone College and the Hinton Hospital School of Nursing. She is a native of Monroe County.

Miss Hart is a native of Valley Bend, West Virginia, and is a graduate of the Buckhannon Hospital School of Nursing.

### Need a New Auto Emblem?

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

## Dr. Carl B. Hall Reappointed to Key National Foundation Committee

Dr. Carl B. Hall of Charleston has been reappointed as a member of the National Foundation's Health Scholarship Committee.

The appointment of Doctor Hall to serve another year as a member of the committee was announced late in May by Dr. Thomas M. Rivers of New York City, Vice President-Medical Affairs of the National Foundation.

The Advisory Committee to the West Virginia State Medical Association's Rural Health Committee met recently to arrange the program for the 13th Annual Rural Health Conference at Jackson's Mill on October 6. Left to right, Gordon L. Leckie of Buckhannon, Dr. N. H. Dyer, State Director of Health, Dr. Earl L. Fisher of Gassaway, chairman of the Rural Health Committee, Mrs. J. C. Huffman of Buckhannon and Doctor Huffman, president of the State Medical Association, Miss Gertrude Humphreys of Morgantown, Mrs. Marie McDougal of Mannington, and Miss Elizabeth Ann Roberts of Morgantown.

## Prominent Physicians to Appear On Allergy Program

Two of the nation's most prominent physicians in the field of allergy have accepted invitations to appear as guest speakers before an open meeting of the West Virginia State Society of Allergy, which will be held during the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

Dr. Merle S. Scherr of Charleston, secretary of the Society, announced that Dr. Ethan Allan Brown of Boston and Dr. M. Murray Peshkin of New York City will present papers at the meeting which will be held on Thursday afternoon, August 25.

Ethan Allan Brown, M. D.

M. Murray Peshkin, M. D.

Doctor Brown, who has served as editor of *Annals of Allergy* since 1942 and who is a past president of the American College of Allergists, will present a paper on "Single Annual Injection Treatment of Pollinosis."

He is a native of London, England, and received his medical training in that country. He came to the United States in 1935 and served for three years as a member of the staff of the Lahey Clinic in Boston.

Doctor Brown served as lecturer and instructor in medicine at Tufts College Medical School, 1939-47, and as assistant professor of pediatrics and consultant in allergy, 1951-58.

Doctor Peshkin, who is Clinical Professor of Medicine and Pediatrics at Albert Einstein College of Medicine, Yeshiva University, New York City, will present a paper on "Respiratory Allergy with Negative Cutaneous Tests to Inhalant Allergens: Diagnosis and Treatment."

He also serves as Consultant Allergist, Mt. Sinai Hospital, New York City, and is Chief Medical Consultant, Jewish National Home for Asthmatic Children, Denver, Colorado.

Doctor Scherr said that in addition to the presentation of papers by the guest speakers, there will be a panel discussion with audience participation. There will also be demonstrations of repository therapy or "single annual injection treatment of allergic diseases."

Dr. Sarah L. C. Stevens of Huntington is president of the Society, and Dr. Marshall J. Carper of Charleston, vice president.

## MLB Licenses 34 Physicians As Result Of Winter and Spring Meetings

The Medical Licensing Board has announced that 34 physicians have been licensed to practice in West Virginia as the result of examinations held in Charleston, January 11-13 and April 18, 1960.

The following physicians were licensed by examination at the January meeting of the Board:

Barber, Daniel Brown, Charleston
Duncan, Thomas Ray, Linden, Tenn.
Harman, Chester Doan, Petersburg
Oceretko, Arkadij, Mullens
Shabb, Samir, Bluefield

Tampoya, Potenciano C., Wheeling
Taylor, John Brookins, Bluefield
Vaziri, Hassan, Milton
Wurster, Wallace Harvey, Beckley

The following is a list of the physicians licensed by reciprocity:

Aceto, Joseph Nicholas, Wheeling
Allen, Kenneth J., Jr., Moundsville
Allen, Samuel Moore, Keystone
Billingsley, John A., Jr., Widen
Bradley, Garnet Beatrice, Chicago, Ill.

Cambor, Charles Glenn, Morgantown
Deal, Clyde Francis, Charles Town
Friday, Gilbert Anthony, Man
Haddon, Joseph Elbert, Williamson
Nesper, Thomas Erwin, Wheeling

Paige, John Harvey, Grant Town
Pruitt, Charles Eugene, Brunswick
Rannels, Herman Wolfe, Man
Schlotterbeck, Mariam Arda, Fairmont
Sinclair, Elizabeth Faye, Beckley
Stelling, Herbert Pund, South Charleston
Sudranski, Herbert F., Elkins

The Board licensed eight physicians by reciprocity at the meeting held in Charleston on April 18. The list follows:

Bryan, John Joseph, Bluefield
Galla, Patrick Paris, Waynesburg, Pa.
Gretchen, Edward Anthony, Weirton
Hall, John Ronald, Elkins

Hartman, John McMaster, Columbus, Ohio
Meek, David Campbell, Beckley
Metcalf, John William, Jr., Steubenville, Ohio
Neilson, Robert Wells, Jr., Bluefield

The summer meeting of the Medical Licensing Board will be held in Charleston, July 11-13, 1960, for the purpose of examining applicants for licensure to practice medicine in West Virginia.

## Allergy Scholarships

The Allergy Foundation of America has announced that summer scholarships have been awarded to 30 medical students in the United States and Canada. The program was inaugurated to enable the recipients to receive supervised training and experience in both clinical and research allergy.

The scholarships, worth $600 each, were awarded to students nominated by the deans of their respective schools in collaboration with the heads of basic science departments at these institutions.

## Source Material Useful in Disaster Planning by Hospitals

A meeting of the Committee on Medical Emergencies and Civil Defense was held at the Daniel Boone in Charleston on May 15, 1960, and the chairman, Dr. George M. Lyon of Huntington, was authorized to prepare for publication in *The West Virginia Medical Journal* an article concerning the availability of source material for use by hospitals in disaster planning.

The article follows:

"Prior to World War II little background information of an organized nature was available for hospitals planning to meet disaster emergencies within their communities.

"Since World War II a great deal of useful information has been prepared and is readily available so that today no hospital need lack for useful information to guide its staff in the preparation of a plan to meet disaster emergencies.

"In 1956 the American Hospital Association published 'Readings in Disaster Planning for Hospitals.' This is a most valuable source of pertinent background information and a must for every hospital. It consists of 90 pages and is available from the American Hospital Association. Some of the articles describe details of disaster planning as considered by various hospitals throughout the country. As expected, the plans made by each of these hospitals apply to their own specific situation but serve to illustrate the various ways disaster services may be planned. Other articles describe actual disasters that have occurred over the past few years as they were experienced by hospitals. The problems faced by these hospitals during the disaster and the lessons they learned with respect to disaster planning are invaluable and should be considered by every hospital in developing their own disaster plans.

"In 1956 the American Hospital Association published 'Principles of Disaster Planning for Hospitals.' This is a small handbook of approximately 30 pages. It outlines individual hospital planning and emphasizes the need for integrating the hospital plan with those of the community. The handbook provides an outline of the general principles of disaster planning which will serve as a guide and check list in developing the specific plan required by the individual hospital. It is the one main source of information bearing directly on methods to be utilized in disaster planning for hospitals. This handbook should be used as the basic guide and is available from the American Hospital Association.

"With these two publications alone those responsible for disaster planning in any civilian hospital can develop a satisfactory 'disaster plan' for that particular hospital.

"The need for community planning for disaster becomes readily apparent from a study of 'Readings in Disaster Planning for Hospitals.'

"Community planning is an aspect of hospital disaster preparations that is often overlooked. It is essential to full-time effective operations during disasters of any type. As a general rule, planning and preparation to meet disaster problems on a community-wide basis can best be carried out when the coordination between hospitals, and between the community and the hospitals, is effected through, or with the assistance of, representatives of the local health department.

"At the State level, the Director of Health, and representatives of his office, are available to assist the local hospitals in their disaster planning. Their services can be invaluable in promoting integrated and well coordinated efforts on a community-wide basis — including not only hospitals but the other resources of the community."

Besides Doctor Lyon, the Committee is composed of Drs. Bert Bradford, Jr., Charleston; C. R. Davisson, Weston; L. A. Dickerson, Charleston; L. Rush Lambert, Fairmont; and Hubert T. Marshall, Morgantown.

## Dr. E. Lyle Gage Guest Speaker At Meeting in Georgia

Dr. E. Lyle Gage of Bluefield presented two papers before a meeting sponsored by the College of Arts and Sciences and the College of Education at the University of Georgia in Athens, Georgia, on June 27. Teachers and other persons working with the University's "Program for Exceptional Children" attended the meeting.

The subjects of Doctor Gage's papers were "Neuroanatomy and Relationships to Mental Retardation" and "Epilepsy and Its Relationship to Retardation."

He also participated in a discussion involving a review of case presentations and was asked to give his recommendations regarding additional diagnosis and remedial suggestions.

## Two State Physicians Certified

Two West Virginia physicians, Dr. Robert T. Brandfass of Wheeling and Dr. Daniel A. Mairs of Charleston, were recently certified by the American Board of Obstetrics and Gynecology.

**Dr. Thomas G. Reed of Charleston (left) and Dr. Charles A. Hoffman of Huntington were among the West Virginia physicians attending the annual meeting of the American Urological Association in Chicago, May 16-19. Doctor Hoffman is chairman of the Association's Public Relations Committee.**

## Twenty-Eight State Students Graduate from MCV

Twenty-eight students from West Virginia received M. D. degrees from the Medical College of Virginia during the 123rd Commencement Exercises held at The Mosque, in Richmond, on June 6, 1960. Twenty-five of the students were graduates of the two-year School of Medicine at West Virginia University.

The following is a list of West Virginia graduates with hospital appointments for 1960-61:

Anderson, Carl L., Glendale
Akron City Hospital
Akron, Ohio

Ashworth, Charles V., Jr., Moundsville
Akron City Hospital
Akron, Ohio

Blake, Dora A., Oak Hill
Grace Hospital
Detroit, Michigan

Boscka, David A., Morgantown
Memorial Hospital
Charleston, West Virginia

Bragg, Arthur D., Gilbert
Stuart Circle Hospital
Richmond, Virginia

Conley, William G., III, Charleston
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Donnally, George A., Oak Hill
Mercy Hospital
Springfield, Ohio

Gemma, Frank E., Clarksburg
Memorial Hospital
Charleston, West Virginia

Ghaphery, James L., Wheeling
Philadelphia General Hospital
Philadelphia, Pennsylvania

Gilliland, Robert L., Belle
Saint Elizabeth's Hospital
Youngstown, Ohio

Hatfield, Kenneth B., Charleston
Saint Joseph's Mercy Hospital
Pontiac, Michigan

Howes, Thomas M., Charleston
Memorial Hospital
Charleston, West Virginia

Kelley, David L., Moundsville
Mercy Hospital
Springfield, Ohio

Kopinski, Joseph C., Scarbro
Saint Elizabeth's Hospital
Youngstown, Ohio

McKown, Charles H., Jr., Wayne
Medical College of Virginia Hospitals
Richmond, Virginia

McWhorter, William D., Clarksburg
Medical College of Virginia Hospitals
Richmond, Virginia

Murphy, Eugene L., Clarksburg
United States Naval Hospital
Pensacola, Florida

O'Connor, Robert D., Charleston
Roanoke Memorial Hospital
Roanoke, Virginia

Pitsenberger, John D., Huntington
Medical College of Virginia Hospitals
Richmond, Virginia

Schwab, Lowell W., Kingwood
Medical College of Virginia Hospitals
Richmond, Virginia

Sheils, John P., Huntington
Roanoke Memorial Hospital
Roanoke, Virginia

Sheils, William S., Huntington
Mercy Hospital
Springfield, Ohio

Stovall, Richard L., Princeton
Memorial Hospital
Charleston, West Virginia

Strader, Janet H., Harman
Memorial Hospital
Charleston, West Virginia

Wells, Hawey A., Jr., Athens
Medical College of Virginia Hospitals
Richmond, Virginia.

Wickham, James R., Grafton
Harrisburg Hospital
Harrisburg, Pennsylvania

Wilson, Thomas C., Clarksburg
Baltimore City Hospitals
Baltimore, Maryland

Wolfe, Walter W., Jr., Parkersburg
Camden Clark Memorial Hospital
Parkersburg, West Virginia

One of the West Virginia graduates, Dr. James L. Ghaphery of Wheeling, was awarded the William B. Porter Prize for outstanding work in medicine.

Under the program that has been in effect for many years, at least 20 graduates of the WVU School of Medicine have in the past enrolled annually at the Medical College of Virginia. Fifteen second-year students at the University will enroll at MCV in September.

## Dr. R. J. Condry Accepts VA Post At Clarksburg Hospital

Dr. Raphel J. Condry of Elkins has accepted appointment on a full-time basis as chief of medical service at the Veterans Administration Hospital in Clarksburg. Announcement of the appointment was made early in May by Dr. Raymond F. Smith, manager of the Hospital.

Doctor Condry has been engaged in private practice in Elkins since 1929, at the same time serving as consultant in cardiology at St. Joseph's Hospital in Buckhannon, and consultant at the VA Hospital in Clarksburg.

### Increase in 'Pop Tax' Collections

Total net collections of the tax on soft drinks reported by the State Tax Commissioner for the month of May, 1960 show an increase of 9.01 per cent over the same month in 1959. May collections totaled $315,581.24, as compared with $289. 504.52 in May, 1959.

## Miss Dorothy Mae Major Named Dean Of WVU School of Nursing

Miss Dorothy Mae Major of Keelersburg, Pennsylvania, has been appointed Dean of the West Virginia University School of Nursing. The appointment was announced by University President Elvis J. Stahr, Jr.

Miss Major, who has wide experience in nursing education and service, will assume her duties at the Medical Center this summer.

She is a graduate of the Hahnemann Hospital School of Nursing, Scranton, Pennsylvania. She received both bachelor's and master's degrees in nursing education at the University of Maryland. She recently completed work toward a Ph. D. degree in education at Indiana University.

Miss Major served as instructor and director of the practical nurse program at the Vocational School in Pensacola, Florida, 1950-51; education director of the Woman's Hospital School of Nursing, Baltimore, Maryland, 1951-53; director of nursing at Franklin Square Hospital, Baltimore, 1953-56; and director of nursing at the Louisville General Hospital, Louisville, Kentucky, 1956-58.

Dr. Kenneth E. Penrod, Vice President-Medical Affairs, said that Miss Major will be responsible for establishing and staffing the new University School of Nursing, which will admit its first class of freshmen in September. The School of Nursing will combine collegiate and professional nursing education programs leading to the degree of bachelor of science in nursing.

Miss Major is a member of the American Nurses Association, the National League for Nursing, and Pi Lambda Theta and Sigma Theta Tau, education and nursing honor societies, respectively.

## Annual Rural Health Conference At Jackson's Mill, Oct. 6

The 13th Annual Rural Health Conference, sponsored by the West Virginia State Medical Association, will be held at Jackson's Mill on Thursday, October 6, 1960.

The announcement was made by Dr. Earl L. Fisher of Gassaway, chairman of the Association's Rural Health Committee, following a recent meeting of that group in Charleston.

The program is being arranged by Doctor Fisher in consultation with representatives of interested farm groups, the Agricultural Extension Service, and the State Department of Health.

Further information concerning the program will appear in future issues of *The Journal.*

## Summer Meeting of MLB, July 11-13

The regular summer meeting of the Medical Licensing Board will be held at the State Office Building, 1800 Washington St., East, Charleston, July 11-13, 1960, for the purpose of examining applicants for licensure to practice in West Virginia.

## Dr. Henry C. Hays Retires

Dr. Henry C. Hays of Williamson, who has practiced medicine in West Virginia for more than half a century, has retired and moved with his family to Athens, West Virginia. He engaged in general practice at Princeton for fifteen years before moving to Williamson, where he practiced his specialty of ophthalmology and otolaryngology for more than 35 years.

He has been a member of the West Virginia State Medical Association since 1911, and in March, 1960, was elected to honorary life membership in the Mingo County Medical Society, the West Virginia State Medical Association and the American Medical Association.

### New Address?

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston 24, West Virginia.

## Dr. W. L. Cooke Honored by MCV Alumni

Dr. William L. Cooke of Charleston has been elected a member of the Board of Directors of the Alumni Association of the Medical College of Virginia. He was named to the post at the Annual Meeting in Richmond on Saturday, June 4.

## New Association Members

Dr. Benjamin H. Biddle, Box 215, Nutter Fort (Harrison). Doctor Biddle, a native of Athens, Ohio, received his M. D. degree in 1916 from the University of Maryland School of Medicine. He interned at Mercy Hospital in Baltimore, Maryland, and had residency training in Chicago and Roanoke, Virginia. He formerly practiced his specialty of EENT in Lancaster, Ohio.

* * * *

Dr. John J. Bryan, Bluefield Sanitarium, Bluefield (Mercer). Doctor Bryan was born in Bisbee, Arizona, and received his M.D. degree in 1954 from the Baylor University College of Medicine. He interned at the U. S. Naval Hospital in Pensacola, Florida, and served a residency at the Bluefield Sanitarium. He formerly practiced his specialty of clinical pathology in Houston, Texas.

* * * *

Dr. Edward A. Gretchen, 3916 Hanlin Way, Weirton (Hancock). Doctor Gretchen, a native of Weirton, received his M. D. degree in 1956 from the St. Louis University School of Medicine. He interned at Akron City Hospital, Akron, Ohio, and had postgraduate training at The Johns Hopkins University College of Hygeine and Public Health. He served for 32 months as a Flight Surgeon in the Medical Corps of the United States Air Force, being released with the rank of Captain.

# 93RD ANNUAL MEETING

of the

# *West Virginia State Medical Association*

## *The Greenbrier*

AUGUST 25-27, 1960

# The West Virginia Medical Journal

August, 1960 Vol. 56, No. 8

# An Aggressive Approach to the Treatment Of Acute Spontaneous Pneumothorax*

## (Case Report)

*Jules F. Langlet, M. D.*

There are many criteria in the management of acute spontaneous pneumothorax. Consequently, almost every practitioner has his own set of rules which aid him in selecting a course of treatment, then guide him during its administration.

In general, however, the treatment most commonly carried out for acute, uncomplicated, spontaneous pneumothorax, either unilateral or bilateral, with only 25 per cent or less lung collapse is conservative. If the lung collapse is more than 25 per cent, mechanical withdrawal of air, either by insertion of a catheter in the pleural space and drainage into a water-seal bottle or by some other method, is performed.

Attention is here drawn to a degree of acute, bilateral, spontaneous pneumothorax in which more rapid re-expansion of the lung is required than that obtained by water-seal catheter drainage. There follows the report of a case of almost complete collapse of both lungs with such limited residual lung capacity that respiratory expansion of the lungs necessary to force the pleural air out into a catheter was inadequate, and a more dynamic approach was required to remove the pleural air.

### Case Report

P. C., a 23-year-old white male, had acute, bilateral chest pain upon arising the morning of November 11, 1958. He tolerated the pain during the morning without comment; during the afternoon, however, he complained of some shortness of breath on exertion and an increase in chest pain. In the early part of the evening, he suddenly became extremely short of breath and was immediately taken to the emergency room of the Charles Town General Hospital where

### *The Author*

- **Jules F. Langlet, M. D., Charles Town General Hospital, Charles Town, W. Va.**

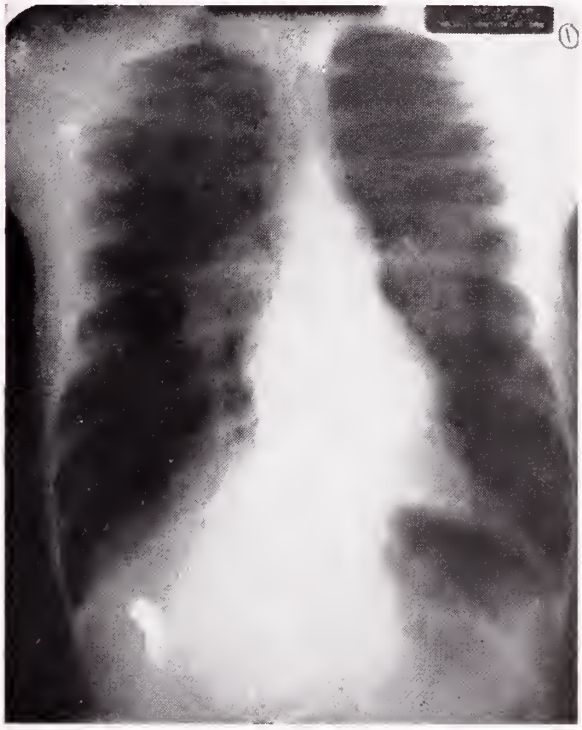

**Figure 1. Bilateral pneumothorax with almost complete collapse of both lungs. The collapsed lung tissue is readily seen about the hilar regions.**

*Presented before a meeting of the Eastern Panhandle Medical Society in Martinsburg, W. Va., November 11, 1959.
Submitted to the Publication Committee, December 31, 1959.

his family physician examined him and had him admitted to the ward.

On arrival at the emergency room the patient was comatose. The blood pressure was unobtainable, and the pulse was weak, thready, and recorded at 132. The respiratory rate was 40; respirations were labored. The face was pale, the skin cool and moist.

Preliminary examination of the chest in the emergency room disclosed bilateral pneumothorax.

Prior to being admitted to the hospital ward, the patient was sent to the Radiology Department where a chest x-ray was taken which showed bilateral pneumothorax with almost complete collapse of both lungs. (Figure 1). Surgical consultation was immediately obtained.

With the patient in bed and in a semi-Fowler's position, the skin about the right anterior axillary line, 7th interspace, was painted with merthiolate. A small stab wound was made and a Clagett S-shaped cannula inserted. The patient being comatose, no local anesthesia of the skin was required, and he did not show any signs of pain even while the pleura was punctured. With the aspiration of pleural air by the chest suction pump, the right lung immediately re-expanded. The color of the skin returned to normal and the patient regained consciousness. The pulse rate was recorded at 96; the respiratory rate was 22 and without undue effort. Breath sounds were well heard throughout the right lung field. The patient complained of being tired and dropped off to sleep.

Chest suction was maintained on the right pleural space for a period of 12 hours. Re-examination of the chest by x-ray at the end of that time disclosed the right lung to be completely re-expanded. (Figure 2). The Clagett S-cannula was then withdrawn and inserted in the left pleural space in the same manner. For this, the skin was anesthetized, with good infiltration of the pleura. The patient still complained of some discomfort when the S-cannula struck the pleura. There was complete re-expansion of the left lung as was evident by clinical auscultation and chest x-ray examination. (Figure 3). Intrapleural suction was discontinued during the evening of the same day. Radiological examination of the chest the following morning disclosed only a small recurrence of air in both pleural cavities.

The patient was given Ilotycin 250 mg. every six hours and a mild sedative for the remainder of his hospital stay. Upon discharge, plans were made for more definite therapy in regard to obliterating the pleural spaces (Figure 4).

Figure 2. The film shows the S-shaped cannula within the right chest and there is complete expansion of the right lung. The left lung is still collapsed and appears as a large left hilar mass.

Figure 3. The film shows the S-shaped cannula within the left chest and there is complete expansion of both lungs.

## Discussion

If spontaneous pneumothorax is of such extent that hospitalization of the patient has been advised, it is the author's opinion, as well as that of many others,[1,2,3,4,5] that closed thoracotomy by some method should be performed. Closed drainage prevents a tension pneumothorax from developing, and the expansion of the lung filling the pleural space will prevent other complications such as emphysema, bronchopleural fistula and captive lung.

The routine use of a chest pump with continuous intrapleural suction drainage in all hospitalized cases of spontaneous pneumothorax has, in the author's experience, greatly simplified the management of these cases.

Following is a course of management which has been established to eliminate many of the past objections to closed thoracotomy and the maintenance of chest suction with an electrically driven pump.

Insertion of a Clagett S-shaped cannula differs little from the method in which a trochar or any other pneumothorax needle is inserted. An area about the 7th interspace, preferably along the anterior axillary line, is cleaned and infiltrated with a local anesthetic agent, making certain that the pleura is well anesthetized. Using a No. 15 knife blade, an incision about 2 cm. long is made. The S-cannula, first having been connected to the chest suction pump, is then inserted. The re-expansion of the collapsed lung usually will cause the patient to cough once or twice, and in almost all cases the patient will immediately feel much improved.

If no large visceral pleural leak is present, the manometric scale on the chest pump will disclose a level of 15 mm. of negative water pressure within a few seconds. We have not seen a chest problem in which the chest pump was unable to maintain within a few minutes the normal 15 mm. of negative pressure. After a period of about one hour, when the patient's anxiety toward chest puncture has subsided and clinical auscultation of the lung discloses that re-expansion has occurred, the drainage tube is doubly clamped and removed from the chest pump. The patient is then taken on a stretcher to the Radiology Department. The Clagett S-cannula remains in the chest and the coils of drainage tubing are placed alongside the patient or across his chest, where he has been instructed to hold them. A chest x-ray is taken with the patient still on the stretcher but in a sitting position, thereby eliminating the inconvenience to him of being transferred off and onto the stretcher, also eliminating the risk of altering the position of the Clagett cannula.

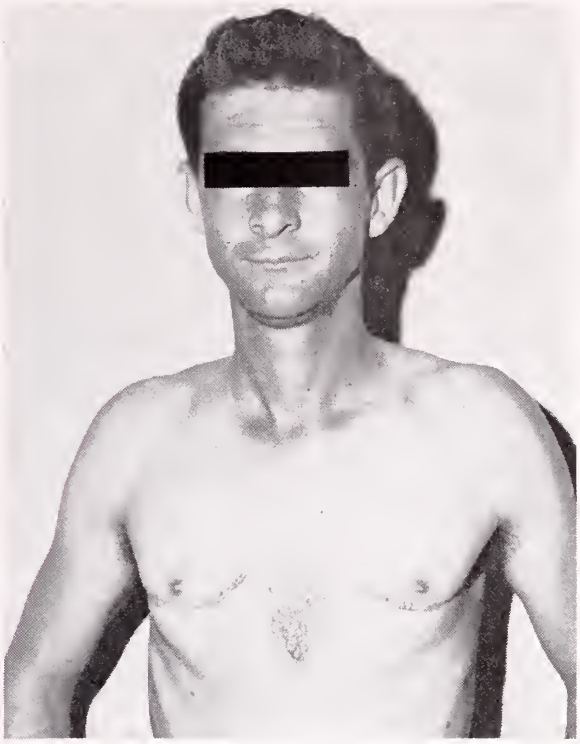

**Figure 4. Immediately after the patient had recovered from the bilateral pneumothorax, he was transferred to the thoracic clinic where a bilateral pleural symphysis was performed. The above view shows the well healed open thoracotomy incisions some 10 months after surgery.**

If the lung is totally re-expanded, the chest suction pump is disconnected; the S-cannula, however, remains in place during the next 12 hours or until the following morning. The patient is then returned to the Radiology Department for another chest film and if no further pneumothorax has developed during the preceding 12 hours, the S-cannula is withdrawn. If air has re-entered the chest cavity, the suction is restarted for the remainder of the day and re-examination made that evening. It has not been necessary to restart the chest pump for a second night on any patient thus far treated.

The chest pump has not caused our limited nursing staff any undue anxiety. To avoid any possible accident at the bedside, the chest pump is fastened to the floor with strips of adhesive tape. We have thus had no difficulty with orderlies or nursing aides altering the position of the pump while sweeping or performing other duties about the patient's bed. The electric plug from the Stedman motor is also fastened with adhesive tape to the electric outlet plate on the wall, thus eliminating any error of accidentally unplugging the unit.

No undue caution need be exercised when the patient is going to or from the Radiology Department. The rubber drainage tubing is doubly clamped with Hoffman screw clamps, and the patient is instructed to hold the coils of rubber tubing across his chest. By clamping the drainage tube and disconnecting it from the chest pump, the patient is able to obtain all chest x-rays in the Radiology Department, and thus secure more accurate films than would be the case if the portable x-ray unit were used.

In contrast is the method of treating pneumothorax by drainage into a water-seal bottle. In these cases the water-seal bottle has to be kept at the proper level if it is taken with the patient to the Radiology Department, and there is always the hazard of the bottle being broken en route.

### Summary


1. At the present time there are three principal methods of treatment for acute spontaneous pneumothorax: (1) bed rest alone, (2) aspiration of air from the pleural space by needle and syringe and (3) closed thoracotomy with water-seal drainage.

2. Closed thoracotomy with Clagett S-cannula and continuous intrapleural suction drainage with chest suction pump as a method of treating all hospitalized cases of spontaneous pneumothorax allows the lung to be immediately re-expanded followed by accurate chest x-ray confirmation. All chest x-rays are obtained in the Radiology Department.

3. The rapid re-expansion of the collapsed lung greatly shortens the hospitalization period.

4. The Clagett S-cannula and chest suction pump enable a more controlled removal of the pleural air without the hazard of lacerating the lung as during a manual thoracentesis using syringe and needle.

5. In cases with a severe degree of bilateral lung collapse such as that in the case reported in this paper, rapid re-expansion of the lung is mandatory. In bilateral pneumothorax the use of a separate pump for each pleural space is advisable. If only one chest suction pump is available, it can be used to re-expand first one lung, then the other, within the time that it takes to check the re-expansion of the first lung by chest x-ray. Such a routine will always enable one lung to be re-expanded should pneumothorax recur on the opposite side.

6. The advantage of having two chest pumps available is also seen in those cases in which a large visceral pleural air leak is present. Both chest pumps can be used simultaneously on a single pleural space if necessary to keep up with the air escaping into the pleural space.


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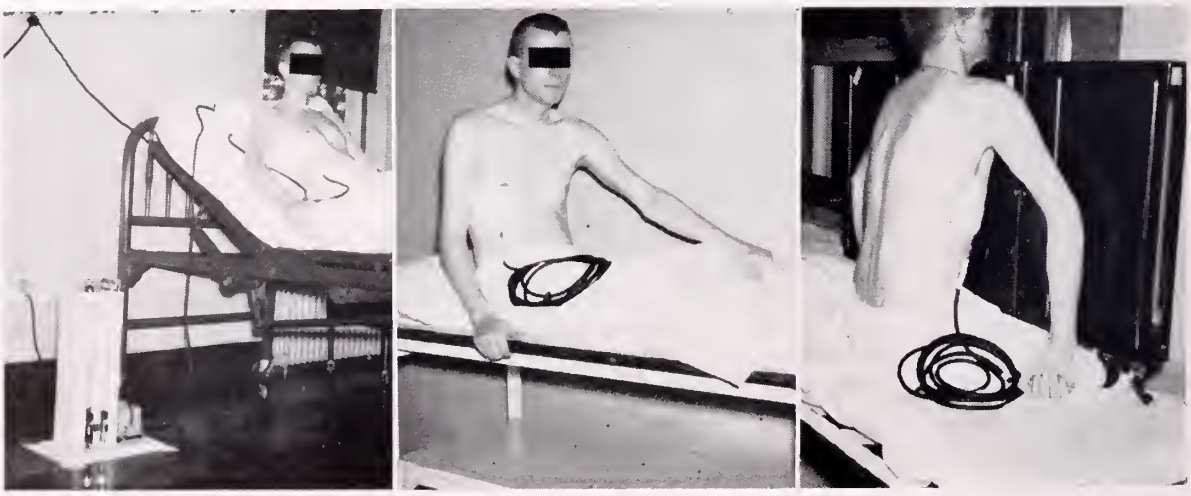

**Figure 5. The Clagett S-cannula in position (left photo) and connected with a length of non-collapsible rubber tubing to the chest suction pump. The chest pump is not a production-line item but is made for the V. Mueller and Company of Rochester, Minnesota, by a local craftsman of that city. The patient is transferred (center) to and from the Radiology Department on a stretcher and instructed to guard the coils of rubber drainage tubing himself. All chest films are obtained in the Radiology Department. The patient is placed in position (right) while still sitting on the stretcher.**

# Experience with Sustained Analeptic Therapy In Geriatric Rehabilitation

*Randall Connolly, M. D.*

In addition to the constant care of the chronically ill, often bedfast patients, the staff of any home for the aged is faced with the demands occasioned by the incontinence, confusion, general untidiness and antisocial activity of the mentally disturbed, senile patient. Any form of practical and safe treatment, therefore, that will lighten these tasks and lead to at least partial rehabilitation of these patients is most welcome. If no more is achieved than to make such patients less irascible, unruly and destructive and more amenable to self care, the time and attention thus saved can be devoted to the more acutely ill.

Considerable evidence has accumulated to indicate that a major part of these behavioral changes in the aged is a function of reduced oxygen in the cerebral blood supply. We have not found the tranquilizers to be the treatment of choice, since they are of little value in combatting cerebral anoxia and their use frequently is attended by serious side-effects in the elderly whose tolerance of these drugs is limited. A more rational approach would appear to be moderate stimulation rather than depression of those faculties which remain, since decreased sensitivity to stimuli is one of the principal causes for many of the physical and emotional malfunctions encountered.

The report of Levy,[1] in 1953, that the combined administration of pentylenetetrazol and nicotinic acid was of significant benefit in correcting behavior patterns in a series of aged, institutionalized patients led us to try this therapy, Geroniazol*, as soon as it became commercially available. Our experience with the drug over the past 5 years has been largely confirmatory of the favorable findings of Levy and subsequent investigators. In vasomotor centers, the therapy appears to have a more complex action in counterbalancing the physiological conditions in the senile psychotic and cerebral arteriosclerotic patient, producing improvement in both soma and psyche, followed by general total improvement.

Recently, the drug was made available to us in a new and unique sustained release dosage form, Geroniazol TT*, which had the obvious advantages over the conventional dosage form in geriatric practice of less frequency of dosage and continuous 24 hour therapy. Our clinical findings during a nine-month study using the new dosage form in 39 patients follow.


## *The Author*

- **Randall Connolly, M. D., 2701 Grand Central Avenue, Vienna, W. Va.**


### Materials and Methods

The medication consisted of an uncoated, unpelleted tablet containing pentylenetetrazol 300 mg. and nicotinic acid 150 mg., designed to release medicaments over a 10 to 12 hour period with a suggested dosage of one tablet morning and night. All patients have been administered the drug for a minimum of 9 weeks, many for the entire 9 months.

The patients selected for the study exhibited degrees of mental disturbance and deterioration characteristic of chronic senile or arteriosclerotic brain syndrome varying from mild confusion to severe dementia. The subjects consisted of 23 women and 16 men, varying in age from 54 to 91 years (average 81 years), drawn from the Masonic Home in Vienna, the Riverview Nursing Home in Parkersburg, and a few from private practice, all of whom had been under our care for one or more years. The prognosis for the majority was generally poor, several having regressed to the point where they were entirely dependent on the staff for existence.

In the absence of a fully qualified psychiatrist or psychologist, none of the standard psychometric procedures was used. Psychological improvement was effectively measured, however, in the following manner: The staff was instructed to observe and record daily, changes in behavior, speech and sleep patterns, appearance, toilet habits, physical activity, sociability, interest, memory, appetite and any other symptoms or findings not previously observed. All observations were reviewed at weekly or bi-weekly

*Geroniazol and Geroniazol TT supplied by Columbus Pharmacal Company.

Submitted to the Publication Committee, April 13, 1960.

intervals, at which time each patient was thoroughly examined by this investigator personally. and graded as to status.

Physiological measurements such as blood pressure, pulse, rhythm, respiration and weight were routinely made at these weekly or biweekly examinations. Blood counts, EKG, and urinalyses were made when indicated. Only those drugs necessary for the physical maintenance of the patient were ordered concurrently. These included Diuril, mannitol hexanitrate, digitalis and reserpine.

In 16 cases showing marked improvement, the drug was discontinued and placebo tablets identical in appearance were substituted, without informing the attending personnel, for a sufficiently long period (usually 2 weeks) to observe any significant change in response.

### Results

Significant improvement was observed in 33 patients (84.6 per cent). Those showing such improvement included 18 patients of a total of 24 who were markedly regressed at the start of therapy, and the total number of 15 moderately regressed patients. Six markedly regressed patients showed little or no improvement. The breakdown of patients according to their original and improved status is presented in the table below.

foul-mouthed and difficult to handle, frequently requiring sedatives and tranquilizers. Improvement began after 10 days on Geroniazol TT therapy alone. Presently, after 9 months on the drug, the patient has progressed from a maniacal to a child-like state, is considerably more tractable and seldom requires sedation. Graded +3, moderate to good improvement.

3.—Female patient, aged 86, with moderate to severe senile dementia, and incontinence. This patient constantly thought another female patient was her husband. Patient now has completed 9 months on Geroniazol TT and is now continent, using the toilet voluntarily. She now only occasionally thinks of the other patient as her husband. Graded +2, minimal improvement.

4.—Female patient, aged 84, with advanced senility. This patient was a chronic complainer with multiple gastrointestinal symptoms, but with no evidence of organic disease. The medication was discontinued after 1 month because of no noticeable improvement and the complaint of nausea. Graded +1, indefinite or no change.

### General Observations

In relating time to response, noticeable effects usually appeared within 1 to 3 weeks of therapy, reaching a maximum in 8 to 12 weeks. The most frequent clinical finding was a marked reduction in confusion, disorientation and memory loss

**GRADED RESULTS OF GERONIAZOL TT THERAPY**

| | *Status Before Therapy* | *Improvement After Therapy* | | | | |
|---|---|---|---|---|---|---|
| *Grade* | | *Marked* 4+ | *Moderate to Good* 3+ | *Minimal* 2+ | *Indefinite or No Change* 1+ | *Total Significantly Improved* |
| Number of Patients | | | | | | |
| Markedly Regressed | 24 | 7 | 11 | 4 | 2 | 18 |
| Moderately | 15 | 3 | 12 | | | 15 |
| Total | 39 | 10 | 23 | 4 | | 33 |
| Percentage | | 25.6% | 59% | 10.3% | 5.1% | 84.6% |

The following examples serve to illustrate the nature and range of response to Geroniazol TT therapy as well as the significance of the grading scale employed:

1.—Female patient, aged 84, with cerebral arteriosclerosis and advanced senility. This patient was completely disoriented and totally incapacitated, requiring constant care and handling in the infirmary. After 4 weeks of Geroniazol TT therapy, the patient was back on her feet, rational, and able to return to her own room and resume normal activities. Graded +4, marked improvement.

2.—Female patient, aged 89, with cerebral arteriosclerosis and a history of severe dementia for the past 12 years. Patient was loud, noisy,

(24 patients). A rather surprising result was the significant improvement found in 10 of 14 patients with delusions and hallucinations. Four patients previously incontinent now use the toilet voluntarily or ask for a bedpan. Of six particularly hostile and irascible patients, four became more tractable and sufficiently sociable to rejoin group activities. Probably the most dramatic response was observed in four previously bedfast, completely dependent patients who became ambulant and capable to a large extent of self-help, requiring minimal staff care. Six previously indolent or vegetating patients became more active and communicative, and more interested in their environment. Vertigo, occurring in 9 patients, was reduced to a minimum, often in

as little as 48 hours. Speech improved in 4 patients who had impairment in this function.

The change to an atmosphere of serenity and cheerfulness from a previous tendency for the patients to be depressed, demanding, noisy and irascible spoke well for the over-all improvement in mood and emotional stability. Psychic improvement appeared to be paralleled in many cases by a general improvement in physical health as evidenced by weight gains (12 to 20 lbs.), improved appetite, less insomnia, increased activity, better appearance and personal habits.

The attendant reduction in work load and the improvement in atmosphere was, of course, enthusiastically welcomed by the staff. In 14 of 16 cases where placebos were substituted, the regression was obvious to attending personnel despite their ignorance of the change in medication. Contact was lost with one of the two patients of the original 16 who were placed on placebo. The other patient was killed in an automobile accident during the period of study.

### Side Effects

The drug was extremely well tolerated in all but 2 patients who complained of nausea. Both of these had a history of chronic complaints with practically every medication previously given them. In the other 37 patients, no side effects whatsoever were noted, even though all patients were specifically observed and questioned in this regard. In several patients with hypertension, rapid pulse, and slow or shallow respiration, there appeared to be some tendency toward normalization with this therapy.

### Conclusions

1. Geroniazol TT administered as a rehabilitative aid in 39 senile patients in homes for the aged produced significant improvement in 84.6 per cent of cases.

2. Twice daily administration of the drug continuously for periods up to 9 months appeared to produce no harmful or significant side effects.

3. The sustained release dosage form has the decided advantages over the conventional dosage form of this therapy of reduced frequency of dosage and continuous 24 hour therapy.

4. The psychic and physical improvement produced in these patients resulted in a marked reduction in staff work load.

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# Of Women's Auxiliaries

Of the many changes in hospital life few are as recent or as striking as those produced by the work of the women's auxiliary groups. The word "auxiliary" still has no definition other than that given us by the great lexicographer as one who "aids, helps and assists." Doctor Johnson applies it only to auxiliary troops; he probably would not have allowed that women might profitably assume duties other than those of the home. But even his conservatism in the matter might have been shaken could he have been confronted with the annual reports of the various modern "auxiliaries."

Perhaps it is at Christmas especially that the significance of these groups becomes most strikingly apparent, when at their "careful and charitable hands," as Sir Thomas Brownie phrases it, so much is done and such thought is taken to brighten surroundings and cheer the sick. In a large hospital the work on Christmas decorations alone may begin as far back as in the summer, and in the Christmas season itself the activity is incessant. On the material side, the financial aid of these auxiliaries, both direct and indirect, can be most valuable. Their contributions to the life and general well-being of a hospital are incalculable.

It takes much hard work, fine leadership and ideals of selflessness to create these organizations. A hospital is a microcosm, and round its central function of caring for the sick there develop multitudes of problems and activities. To deal with these effectively, unobtrusively and pleasingly as do these auxiliaries, is to practice in all its beauty the meaning of that still lovely word charity.—Canadian Medical Association Journal.

# Carcinoma of the Lung: Combined Therapy*

*R. N. de Niord, Jr., M. D.*

It would seem that our current literature is replete with every possible approach to the treatment of pulmonary cancer. While this is in a sense true, the solutions range from radical resection to no resection, and the use of nitrogen mustard in conjunction with some form of x-ray. This paper presents an approach to lung cancer based, it is felt, on a logical program consisting of the combined use of surgery, cobalt or x-ray therapy, and nitrogen mustard.

We have all been interested in the recent work of Cole[1] and his associates on the circulation of cancer cells in the blood and the effect of various carcinolytic agents on these cells. Fisher,[2] Engle[3] and others also have performed studies on the determination of free cancer cells in the blood in various forms of visceral neoplasm. In experimental studies, suspensions of the Walker 256 rat carcinosarcoma were injected into the portal veins of rats. There was a reduction in the tumor "takes" in approximately 95 per cent of the controls when this injection was followed immediately by injection of nitrogen mustard. Delayed injection of mustard, that is, for 6, 24 and 48 hours, had little prophylactic effect on the "take" areas. These studies seem to indicate that the presence of tumor cells in the blood, especially following surgery of a visceral cancer, may in a sense dictate the curability of the lesion.

A large or bulky carcinoma of the lung handled roughly by the operator must almost certainly discharge large numbers of free and viable tumor cells into the venous blood. These may then lodge anywhere in the general systemic circulation and become seedings for new growth. The surgeon has done the patient a disservice by such an operation and indeed may have disseminated rather than resected the lesion. It seems logical, therefore, to approach the treatment of carcinoma of the lung from a threefold point of view: (1) successful resection of the tumor with emphasis on careful handling of the lesion, and ligation of the pulmonary vein prior to arterial ligation, (2) judicious administration of nitrogen mustard intravenously at the time of surgery to destroy viable tumor cells in the blood stream and (3) the use of cobalt or x-ray therapy to the mediastinum in the postoperative period in order to "sterilize" the remainder of lymphatic tissue in that region.

***The Author:***

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It occurred to us that a patient having a clean and curative resection for isolated carcinoma of the lung should be given every opportunity for a cure with the initial use of adjunctive agents. Unlike that of a hormone dependent tumor such as breast or prostatic carcinoma, success in treatment of lung carcinoma depends on the initial effort and not on treatment of the recurrence. Every effort should be made, therefore, to remove primarily as much tumor as possible and to prevent recurrence by the immediate use of adjunctive agents. I have used this approach even when a clean resection has been performed, with the hope of improving the rather poor five-year statistics for lung cancer.

We are presenting a series of 39 cases of carcinoma of the lung in which the patient underwent operation by us during the past year, and have indicated those in which a cure may have been obtained. In all, 54 patients with the diagnosis of carcinoma of the lung were seen but only 39 were suitable for surgery.

**Table 1**

| | *No.* | *Un-Re-resect-able* | *Resect-able But In-curable* | *Resect-able and Curable* |
|---|---|---|---|---|
| Epidermoid carcinoma | 18 | 8 | 3 | 7 |
| Alveolar cell carcinoma | 8 | 0 | 2 | 6 |
| Adenocarcinoma | 3 | 0 | 1 | 2 |
| Anaplastic carcinoma | 10 | 2 | 8 | 0 |

Table I demonstrates the series of cases and reveals the type of tumor present. In 18 cases, the patient had epidermoid carcinoma of the lung, 8 had alveolar cell carcinoma, 3 had adenocarcinoma, and in 10 cases the lesion was anaplastic or undifferentiated. In all but two cases (the latter being alveolar cell carcinoma) there was the history of heavy consumption of cigar-

*Presented before a meeting of the Association of Surgeons of the Chesapeake and Ohio Railway, at The Greenbrier in White Sulphur Springs, November 4, 1959.

Submitted to the Publication Committee, December 23, 1959.

ettes, more than a pack a day for fifteen years. This was arbitrarily used as a basis for designating a heavy smoker, although with no sound evidence to back it up. At any rate, the correlation between heavy cigarette smoking and carcinoma of the lung is verified in this small series of cases.

Ten patients were unresectable, that is, the tumor technically could not be removed at the time of operation. Fourteen patients were resectable but incurable. This term refers to the fact that the tumor technically could be removed but had areas of obvious extension to the hilar lymph nodes, parietal pleura, and chest wall. We consider these patients resectable but incurable in the sense that lymphatic extension or metastasis already has occurred. Some of these patients had rather wide radical resection with removal of all lymphatic tissue in attempting palliation and removal of the bulk of tumor mass and nodes so that x-ray therapy would be more efficacious. It is almost certain, however, that microscopic extension was left behind and these patients therefore are placed in the resectable but incurable category.

The last category is resectable and curable, and in this there are fifteen patients. These had curable resections in that all tumor could be completely removed as well as possible lymphatic extension. Total pneumonectomy was not done in all cases; in some, it was felt that complete removal of an isolated lesion within the lobe was adequate and resection was limited to lobectomy. Those tumors which crossed a fissure line or seemed to be centrally located so that lobectomy could not sensibly be done were removed by pneumonectomy.

### Preoperative Evaluation

It is important to evaluate the patient's condition carefully from the point of operability. A wise selection of patients, that is, discarding those with signs of inoperability, will prevent unnecessary surgical procedures. Our feeling regarding inoperability is as follows: (1) Bloody pleural effusion with tumor cells indicates pleural involvement and incurability. Bloody effusion with viable tumor cells present certainly indicate a sloughing or seeding of far advanced surface carcinoma under the pleura and means that thoracotomy would be of no avail. This type of patient responds poorly to any form of therapy since multiple lymphatic extensions within the visceral and parietal pleura exist. (2) Phrenic nerve involvement with paralyzed diaphragm. This can be seen easily at the time of fluoroscopy since parodoxical motion will exist on the involved side. A large tumor mass with paralyzed diaphragm and paradoxical motion certainly would indicate extension to the pericardium with contiguous involvement of the phrenic nerve, and obviate the possibility of cure. There are some isolated instances in which a small metastatic or direct tumor spread to the pericardium will involve the phrenic nerve but, in general, this sign indicates a large bulky tumor with direct extension to the root of the lung involving the pericardium. (3) Recurrent nerve involvement with hoarseness. This indicates that the tumor mass has burrowed deeply beneath the aortic arch to involve the recurrent nerve, and that resection would be difficult, hazardous and probably not possible. (4) Distant metastasis, especially cerebral, obviously contraindicates thoracotomy.

Once the state of operability has been established, the general physical condition of the patient must be scrutinized. There are certain routine tests which should be run in all cases of pulmonary lesion. These include: (1) Skin tests for tuberculosis and the three fungi (histoplasmosis, blastomycosis and coccidioidomycosis). (2) Fluoroscopy to determine the location of the tumor, whether or not the diaphragms move well and equally, the cardiac action and the aortic pulsations. (3) Bronchoscopy. At this time saline washings for cytology and culture should be obtained, also care taken to observe the carina since this area must be completely free of tumor before resection can be considered. A biopsy specimen is removed from the tumor mass if one is seen, or a random specimen if tumor is strongly suspected. Often a submucosal extension of tumor may be picked up in this fashion. (4) Observation of the vocal cords at the time of bronchoscopy or by indirect laryngoscopy to be sure that recurrent nerve involvement has not occurred is important.

**Table 2**

**CONTRAINDICATIONS TO SURGERY**

1. Bloody pleural effusion with tumor cells indicates pleural involvement and incurability.
2. Phrenic nerve involvement with paralyzed diaphragm
3. Recurrent nerve involvement with hoarseness
4. Obvious distant—especially cerebral—metastasis

This program, if instituted at once in the evaluation of a patient with a pulmonary lesion, will prevent much unnecessary difficulty and will considerably lessen the number of months of observation and confusion which frequently complicate the picture. The lag period from onset of symptoms to definite procedure in most patients is directly related to the lack of a well

coordinated program when the patient is first seen. In this series of cases there was a lag period averaging 3½ months from the first physician visit to definite treatment. This is too long. In most cases delay is due to one or more factors: (1) Wishful thinking on the part of the physician that he is dealing with a benign pneumonia and that prolonged treatment with antibiotics and observation are indicated. (2) Natural resistance on the part of the patient to face the fact of a possible lung tumor, with the necessity for exploration.

It is therefore emphasized that on the initial visit the patient with a nonspecific, pulmonary infiltration receive the above tests, that is, bronchoscopy, fluoroscopy and skin tests. Once these studies are completed it is possible to treat with broad spectrum antibiotics and observation for a period of four to six weeks. If, at the end of this time, the lesion has not cleared and if none of the diagnostic studies and cultures is positive, exploratory thoracotomy is mandatory. The unhealthy lag between the moment of diagnosis and the moment of definite treatment simply extends that time when the tumor can locally infiltrate, spread to the lymphatic system, and prevent curable resection.

If the initial lesion as seen on x-ray is poorly circumscribed, does not contain calcific laminations, and is obviously not a well localized granuloma, exploration is almost immediately indicated. In such cases bronchoscopy is not entirely necessary; the usual skin testing, however, is performed.

If the pulmonary lesion is well circumscribed, with calcific laminations, this probably represents a benign granuloma, either tuberculoma or histoplasmoma, and one can feel safer about follow-up with intermittent x-rays. A word of caution is indicated here in that an occasional carcinoma of the lung can contain areas of calcium; these, however, usually are not laminated or concentric, and the lesion usually is not well circumscribed or round. The lobulated or poorly defined lesion, even though it may contain specks of calcium, should be strongly suspected unless these laminations and well defined borders are present.

### Operative Procedure

The next phase of treatment is the operation itself. Points of emphasis here are as follows:

(1) Gentle exploration with care not to massage or disturb the tumor mass. It seems obvious that discharging large numbers of tumor cells into the circulation would follow a heavy massage or squeezing of a bulky tumor.

(2) Frozen section study of the hilar lymph nodes if they appear enlarged. If the hilar nodes are normal, the tumor mass peripheral and small, this is not necessary. If these glands are in any way enlarged, however, removal and frozen section should be done to determine the presence of tumor cells. If the carcinoma has extended to the mediastinal lymph nodes, they should be excised, in so far as possible, by skeletonizing the trachea, if necessary, removing the pericardium and in general removing as much of the contained lymph nodes as possible. It should be pointed out that the original concept of Mr. Allison, of Oxford, concerning radical pneumonectomy, now regularly applied by Watson,[4, 5] is in opposition to this approach. These observers feel that radical resection should be performed even for small peripheral carcinoma as is the philosophy with breast carcinoma. It seems to us, however, that the statistics so far do not support this type of surgery. We have reserved extensive mediastinal node dissection for the patient having, either microscopically or grossly, involved hilar lymph nodes. Other authors currently support this view.[6, 7]

**Table 3**

**TECHNIQUE AT TIME OF OPERATION**

1. Gentle exploration with care not to massage the tumor mass
2. Biopsy and frozen section study of hilar lymph nodes if they appear greatly enlarged
3. Biopsy of tumor mass per se contraindicated for fear of seeding tumor cells
4. Choice of lobectomy versus pneumonectomy depending on location of lesion. If mass distinctly within one lobe without any extension across a fissure and no hilar nodal involvement, a lobectomy may safely be done.
5. Early ligation of pulmonary vein before arterial ligation
6. Use of intravenous nitrogen mustard following removal of the lesion—usually 10 mg. N2H

(3) Biopsy of the tumor mass *per se* is contraindicated for fear of seeding tumor cells. Only suspicious metastatic areas need be biopsied.

(4) Choice of lobectomy vs pneumonectomy depending on the location of the lesion. If the mass is distinctly within one lobe and without extension across a fissure, then lobectomy may safely be done.

(5) Early ligation of the pulmonary vein before arterial ligation. This is self-explanatory. If the vein can be securely ligated before the tumor mass is disturbed in any way, viable cancer cells may be contained within the lobe involved and not discharged into the systemic circulation.

(6) The use of intravenous nitrogen mustard following removal of the lesion. This usually consists of 10 mg. intravenously although occa-

sionally 20 mg. is given in a large individual. We do not give a total dose (0.4 mg. per kilogram) at this time, feeling that significant leukopenia often ensues if this is done. Furthermore, we do not treat the patient with nitrogen mustard in the postoperative period since its initial effect at the time of surgery is all that is desired, that is, the destruction of viable tumor cells within the circulation. This is not to imply that we do not use nitrogen mustard on those patients with superior mediastinal tumors or recurrent lung carcinoma.

Following the above procedures the patient is watched carefully for several weeks following surgery to be sure that significant leukopenia does not exist. If this does occur, continued treatment with broad spectrum antibiotics and occasional transfusions suffices to improve the low white count.

At approximately four to six weeks following surgery the patient is given a course of x-ray or cobalt therapy directed at the mediastinum and hilar area to sterilize these lymphatic extensions. If cobalt therapy is used a tumor dose of approximately 5,000 r's is delivered over a four-week period if the patient can tolerate this rapid administration. Usually, treatments are given Monday through Friday with a respite on the weekend. This allows the patient to return to his home on Friday and come back early Monday morning. If conventional x-ray is used, a tumor dose of approximately 3,000 r's is employed over a six-week period. It has been our experience that most patients have tolerated this therapy, especially cobalt therapy, well. Most, however, do experience various degrees of anorexia, malaise and, occasionally, leukopenia.

In many patients receiving cobalt, esophagitis and tracheobronchitis develop due to radiation irritation which lasts anywhere from three to five months. These conditions are manifested by a rather persistent cough, dysphagia and actual difficulty in swallowing.

Table 4 demonstrates five-year statistics of several rather large series of lung cancer. It is of interest in this chart that those patients who were resectable in most of these series carried a five-year cure average of from 20 to 25 per cent, a rate considerably higher than the less than 5 per cent reported by those who lump unresectable and resectable lesions in one group. This fact certainly places carcinoma of the lung in a different light and makes one feel that an early diagnosis is especially important since this may mean the difference between resectability and incurability.

**Table 4**

| *Senior Author and Year* | *Number Resected* | *Percent Resected Patient 5-Year Survival* |
|---|---|---|
| Churchill—1950 | 69 | 14.5 |
| Overholt—1956 | 234 | 22 |
| Ochsner—1956 | | 15 |
| Watson—1956 | | |
| Radical Pneumonectomy | 74 | 27 |
| Less than radical pneumonectomy | 42 | 23.8 |
| Gibbon—1956 | 145 | 21 |
| Johnson—1958 | 116 | 26.7 |

### Summary and Conclusions

We feel that certain points are worthy of emphasis in the treatment of patients with suspicious pulmonary lesions: (1) Early diagnosis and operation, with care to select only those patients who appear to have a resectable lesion. Thoracotomy is contraindicated when there is phrenic nerve involvement, recurrent nerve paralysis, or bloody effusion with bronchial biopsy or pleural fluid study indicating the presence of tumor cells. (2) Patients falling into the group who can be explored are then treated with great care to avoid handling the tumor mass, with early ligation of the pulmonary vein, and with care to determine the presence or absence of involved nodes at the mediastinum. (3) Nitrogen mustard is used at the time of surgery to decrease the number of viable tumor cells circulating in the blood stream. (4) Cobalt or x-ray therapy is used in the post-operative period to attempt sterilization of the mediastinal lymphatics or hilar lymph nodes. (5) The lag period of 3.5 months between first physician visit and definite thoracotomy in this series indicates the need for an organized program on the part of general medical personnel. This would consist of early skin tests, bronchoscopy, sputum cultures and a test period of four to six weeks of broad spectrum antibiotics. If, at the end of this time, a nonspecific pulmonary lesion has not cleared, we strongly urge pulmonary biopsy or exploratory thoracotomy.

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# Modern Occupational Medicine

MODERN occupational medicine is that branch of medicine which deals with the relationship of man to his occupation for the purposes of the prevention of disease and injury and the promotion of optimal health, productivity, and social adjustment.

Employee health is the province of the industrial medical department. Optimally, this is a team of doctors, nurses, technicians and clerical staff whose objectives are best accomplished through an in-plant medical service.

The improvement of the health aspects of the physical environment at work is the joint responsibility of the medical department, the industrial hygienist, the engineer and chemist.

Occupational diseases and injuries are predictable on the basis of a study of materials and processes. By the same token, both should be preventable. The prevention of occupational disease has been much more successful than the prevention of injury because of the larger introduction of human factors in the latter.

Preventive medicine is more than disease prevention. Through periodic examinations, health education and counselling, some diseases may be diagnosed early enough to be cured. Others not amenable to cure may be kept under sufficient control so that normal living, normal productivity, and normal longevity may be achieved.

It has been demonstrated that there is a relationship between health, both mental and physical health, and accident frequency. It is estimated that the majority of accidents on and off the job are attributable to the man factor and not the machine. The medical staff in industry are specialists in man just as the engineer is a specialist in the machine. Machines change, but man, though adaptable to change, does not change.

Medical science and engineering science have pooled their skills for the improvement of safety on the job. Lessons learned from the successful use of these skills in large plants can be applied to the small plant as well.—David Goldstein, M. D., in American Association of Industrial Nurses Journal.

# A Study of the Disabilities of Aged Patients In a Community Nursing Home

*Louis W. Groves, Harlan D. Sponaugle and Clark K. Sleeth, M. D.*

CARE of the aged and chronically ill rapidly is becoming a matter of foremost medical, social and economic importance. The situation is due in part to improvement in standards of living and in diagnosis and treatment of acute infectious diseases. An enumeration in 1954 showed 14 million persons in the United States past the age of 65. It is estimated that by 1975 the figure will have reached 20.5 million.[1]

Increasing numbers of these older persons are living for long periods in public, private and semiprivate institutions, of which there were 25,000 in the United States in 1954, with an overall capacity of approximately 450,000 persons. Seven thousand were nursing homes employing registered nurses and designated as skilled nursing homes. In West Virginia at that time there were 51 skilled nursing homes, with a total capacity of 1,700 persons.

### Survey at Sundale

A survey was conducted at the Sundale Rest Home, 449 Van Voorhis Road, Morgantown, West Virginia, during the months of June and July, 1959. Its purpose was to determine certain characteristics of the patient population including an estimate of the group's rehabilitation potential.

The factual information included in the survey was obtained from several sources. The medical file, including history and physical examination of each patient was studied. Fairly complete data were available for the 18 months prior to survey and in some cases for many years past. The survey team held several consultations with the attending physician and talked with the individual patients. The team also assisted with routine nursing care and laboratory study of patients during the survey period.

Sundale Rest Home is a nonprofit, largely self-supporting institution, and is governed by a Board of Directors composed of local citizens. The legal title to the property is vested in the County Court of Monongalia County. The physical plant is a three-story brick building adjacent to the Monongalia General Hospital, with a bed capacity of 143. Accommodations are divided into private room, semiprivate room and ward.

Submitted to the Publication Committee, March 8, 1960.


## *The Authors*

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### Sundale's Staff

The staff consists of 4 registered nurses, 1 registered practical nurse, 3 male attendants, 1 housekeeper, 20 female nurse aides, and 9 kitchen employees. Medical care for the patients is provided by one staff physician who makes rounds twice a week and three internists from the West Virginia University School of Medicine who make periodic visits. Consultation services in other specialties can be obtained from amongst the practicing specialists of the area. Private patients may use the services of the staff physician or arrangements for their care by private physician may be made, if desired.

### The Patients

The total patient population of Sundale Rest Home as of June 5, 1959 was 74, of which number 41 were females and 33 were males. The mean age of the group was 78.8 years. Age distribution was:

| | |
|---|---|
| 50-59 years | 2.7% |
| 60-69 " | 9.5% |
| 70-79 " | 33.7% |
| 80-89 " | 47.2% |
| 90-99 " | 5.4% |
| 100 or more years | 1.5% |

### Sources of Income

Defrayment of expenses for the care of these patients was provided from the following sources:

| | |
|---|---|
| Department of Public Assistance | 43 % |
| Private Pay | 33 % |
| Department of Public Assistance + Social Security | 10.5% |
| Department of Public Assistance + Private Pay | 5.5% |

Pay for the remainder of the patients was from a combination of several sources.

### Patient Care Required

In evaluating the amount of care required by each patient, it was found that 55.4 per cent were ambulatory and fed themselves, 35.1 per cent were non-ambulatory but fed themselves, and 9.5 per cent were non-ambulatory and did not feed themselves.

### Patient Orientation

In any group of patients in this age bracket, there are many for whom the state of orientation invariably is a problem. At Sundale we found that 66.2 per cent were fully oriented. Two-thirds of the remaining number were moderately disoriented and one-third were extremely disoriented.

The inability of some of the patients to move about created another serious problem. Fifty-six per cent were fully ambulatory (includes use of canes and walkers), 23 per cent were confined to wheel chairs and 21 per cent were bedfast.

### Chief Causes of Disability

An attempt was made to evaluate the medical reason for the presence of the patient in the nursing home, with the following result:

| | |
|---|---|
| Age alone | 60.8% |
| (No specific disease entity recognized) | |
| Cardiovascular disease | 43.2% |
| Joint disease | 35.1% |
| Fractures and their sequelae | 12.1% |
| Parkinsonism | 5.5% |

Approximately 46 per cent presented two or more of the conditions outlined. Other findings commonly present were prostatism with or without urinary tract infection, pulmonary emphysema, chronic urinary infection in the female, visual and auditory impairment, "chronic constipation," generalized weakness and debility.

### Rehabilitation and Improved Medical Care

The following observations were made with regard to the possibility of rehabilitation and of improved medical care for this group. They were based on the assumption that unlimited resources would be available.

In recent years there has been a change in thinking regarding the etiology of senile psychoses. In a report made by the University of Texas covering the years 1950 to 1954 and including 1,134 patients, 70 per cent of the cases were found to be functional rather than entirely the result of arteriosclerosis or other structural change. It was recommended in the report that restoration toward normal function be directed toward physical and psychotherapy. The former approach was simply a matter of satisfying physical needs which, if left unattended, may lead to depression and psychoses in any age group. Psychotherapy was provided by means of drug therapy, electroconvulsant therapy and simple kindness and interest in the patient as a person.[3]

The effectiveness of the last mentioned cannot be over-stressed for in many instances during the course of the survey, it was observed that the anticipation of a visit from a member of the patient's family or of a short visit to the home of a relative greatly improved the patient's morale and well-being. This approach could be expanded readily through the services of trained or volunteer social workers. When the desire for personal attention and adequate social intercourse is not fulfilled, many patients tend to accentuate minor physical ailments thus diverting the services of medical and nursing personnel. Possibly the cost of social work would be no greater than that incurred through the misplaced application of nursing and medical care. Moreover, there exists the possibility that through social work and psychotherapeutic treatment some patients may be able to return permanently to their families thereby putting an end to the heavy expense of institutionalized care.

For the nonfunctional senile changes, the use of high protein diets, vitamins, hormones and mild analeptics should be considered.

In regard to patients afflicted with cardiovascular disease, especially those with resultant paralysis, one must think in terms of physical therapy and development of vocational rehabilitation programs. Proper programs can be of twofold value in that they benefit the patient psychologically and are of remunerative value to him as well as to the community. Not all patients who have suffered cerebrovascular accidents are candidates for vocational rehabilitation; many severely handicapped, however, can be taught ambulation, self-care, and urinary and fecal continence, if the help and facilities are available.

In Sundale's patient population of 74, 35.1 per cent were found to have some degree of arthritic change. This ranged from mild degenerative joint disease to rheumatoid arthritis (the latter in one case, the patient a 51-year-old male). Some of these people could be benefited by physiotherapy and orthopedic surgery as well as other formal vocational rehabilitation procedures.

### Fracture in Females

It was interesting to note that of the 9 patients with fracture, 8 were females. Apparently in the postmenopausal female this is a common hazard, possibly because of osteoporosis due to the low estrogen level, and this is especially true of fracture of the head and neck of the

femur. It would seem that the judicious use of hormone therapy, high protein diet, and mineral supplement in the care of elderly postmenopausal females would be of benefit in reducing the number of fractures.[4] The question, however, of the carcinogenic effect of hormones has not been settled, and the patient should be thoroughly examined before such therapy is started.

In the treatment of existing fracture, the above regimen should be followed, in addition to using to the fullest the services of an orthopedist and a physiotherapist. The role of the physiotherapist is important in minimizing muscular atrophy thus aiding in early ambulation as well as giving encouragement to the patient. Some form of occupational therapy is an important part of the treatment of fractures, as well as rehabilitation during and following any long illness. These programs, if possible, should be economically profitable; if not possible, however, an effort should be made to provide the patient with some enjoyable diversion.


**Summary**

A survey was made in a skilled nursing home during the summer of 1959 for the purpose of evaluating certain characteristics of the patient population. Characteristics evaluated were age, defrayment of expenses, state of orientation, ability to ambulate, and the main medical reasons leading to admittance.

Recommendations for rehabilitation and improved medical care are presented.


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# More About The Forand Bill

It must be remembered that the Forand Bill is only "a foot in the door." After its passage expansion would be bound to follow. Other age groups would be included until socialized medicine would be a *fait accompli*—by a gradual stealthy, creeping, insinuating, infiltrating process. It would not be long until we had the "whole hog." We would not have gotten it all at once, as was proposed in 1948, but by a gradual process so that we would have it before we knew it. You may be sure that if this bill is passed, others will follow. We must defeat this one *now*. If we do not, and this bill and other similar ones are passed within the next few years, it will be too late for us to think about it. We will have had it.

Two lines from a famous lament are appropos here:

*"It isn't love's going that hurts my days,*
*But that it went in little ways"*

Federal aid to medical schools by itself is not socialism; neither is Federal care of the health of school children; neither is free lunches for school children; neither is Federal aid to education; neither is the total disability bill. But Federal aid to schools, plus TVA, plus agricultural benefits, plus public housing, plus the Forand Bill is socialism. It is incomprehensible to think that we have gone so far along the primrose path of dalliance. What has become of the toughness and sturdiness of character which characterized our people until 1933?

Unless present day trends in government are checked promptly and effectively, a few years hence (and not very many at that) we may find ourselves substituting the word "Liberty" for "love" in the two lines of poetry quoted above, and repeating these lines in bitterness and self reproach.—Amos R. Koontz, M. D., in Current Medical Digest.

# The President's Page

## Looking Back

THE year 1960 has been one of momentous decisions for the medical profession as well as for our national political figures. We, the officers, council and delegates of the West Virginia State Medical Association hope that our deliberations, decisions, and actions have in some measure met with the approval of our members. I can assure you, as your president, that every officer, committee chairman and member has worked hard to fulfil his obligation to our organization. We hope that our labors have not been in vain.

The AMA Convention, held in Miami Beach, June 13-17, 1960, was not as well attended as some in the past. This was due in part to an airline strike. There were nearly nine thousand physicians in attendance. Your State Medical Association was represented by the following officers: Holroyd, Hoffman, Vest, Hash, Evans and Huffman. Many members were also present from over the state, as were the Livelys from the headquarters offices.

We were privileged to hear speeches by Paul Butler and Thurston B. Morton, chairmen, respectively, of the Democratic and Republican National Committees. They appeared at the Conference of Presidents and Other State Officers on June 12. At that same meeting John H. Furbay, Ph.D., director of global education for Trans World Airlines, "the most traveled man alive," gave a most interesting presentation on the subject of "Wings Over the World." After hearing these men, I was more convinced than ever that doctors of medicine must take time from their busy practice to help meet the urgent economic, political and social problems that face our society on a local, national and international basis. We are most fortunate to have such leaders as Dr. Louis M. Orr and Dr. E. Vincent Askey to guide the affairs of organized medicine. It is our individual responsibility to keep informed of their activities.

The more than 100 scientific sessions were well attended. Each of us had ample opportunity to select the subjects that were of most interest to us. I found the sessions on General Scientific and General Practice to my liking. Also, there were scientific and commercial exhibits at the Miami Beach Auditorium, where one could spend endless hours absorbing valuable information.

The AMA House of Delegates met at the Americana Hotel, where such subjects as Health Care for the Aged, Pharmaceutical Issues, Occupational Health Programs, Allied Health Groups, National Foundation, Voluntary Health Insurance, Foreign Medical School Graduates, Commission on Cost of Medical Care, Social Security for Physicians, and various other subjects were discussed, all of which is reported elsewhere in this issue of *The Journal.*

With the closing of the West Virginia State Medical Association Convention in August, I give thanks for the helping hand of my able predecessor, George Evans, to the various committees and their chairmen, and to the Livelys and their office force. To my successor, John Hash, I pledge my wholehearted support for the good of organized medicine. I am especially grateful to the Woman's Auxiliary for their generous help. It has been a great privilege to serve the membership of the West Virginia State Medical Association during the past year.

J. C. Huffman, M. D., President

# THE WEST VIRGINIA MEDICAL JOURNAL

*Official Organ of the West Virginia State Medical Association*

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*Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.*

*Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone Dickens 4-4625.*


# EDITORIALS

## A DATE FOR LATE AUGUST!

The program for the 93rd Annual Meeting of the West Virginia State Medical Association has been completed and is printed elsewhere in this issue of *The Journal*. A mere glance at the program will, we are sure, convince everybody that it is one of the most outstanding that has been arranged for an Annual Meeting in modern times.

We hope that all of our members will take time to study the program. Not only will the morning sessions be interesting, but exceptionally good programs have been arranged for section and society meetings afternoons during the Convention.

As usual, there will be several meetings of standing and special committees on the Wednesday afternoon preceding the formal opening of the Convention on August 25. The pre-convention meeting of the Council is scheduled for four o'clock, and the first meeting of the House of Delegates will be held that evening at 9 o'clock.

Although Dr. J. C. Huffman of Buckhannon will deliver his presidential address at the first meeting of the House of Delegates, he will continue to serve as President until the close of the second session on Saturday afternoon.

Increasing interest is shown over the years in the annual meetings at The Greenbrier. One of the advantages of booking meetings at this famous resort is the fact that "everything" is under one roof. Exhibits will be opened each morning at eight-thirty, in time for those who care to do so to make an early morning round of the Exposition Hall before the scientific session is called to order. The usual breaks will be arranged during morning sessions so that everybody will have an opportunity to visit the

J. C. Huffman, M. D.
President

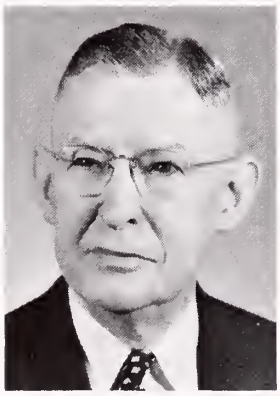
exhibits, which will undoubtedly be the most interesting ever arranged for an annual meeting.

We feel that it is unnecessary for us to extol the virtues of The Greenbrier as a convention hotel. The members of the State Medical Association, Auxiliary and guests, as well as the many exhibitors who will be present, are already fully cognizant of the facilities available there. Proof of the popularity of this world-famous resort is evidenced by the heavy advance reservations for accommodations. With the Convention nearly six weeks away, reservations as of this date (July 15) have already passed the six-hundred mark.

We hope that all of the members of the State Medical Association and Auxiliary who can possibly do so will make arrangements to meet us at The Greenbrier on Wednesday afternoon, August 24, and remain until after the cocktail hour and dinner on Saturday night. A cordial welcome awaits all who attend the Convention.

## ROY BIRD COOK—AN APPRECIATION

Dr. Roy Bird Cook of Charleston has been reappointed by Governor Cecil H. Underwood to an unprecedented 8th consecutive five-year term as a member of the State Board of Pharmacy. The reappointment of Doctor Cook by the Governor to this important office will come as welcome news to the members of the medical and pharmaceutical professions who have followed with much more than passing interest the career of one of West Virginia's outstanding citizens, one who has really risen through the ranks to the highest office in his profession.



Dr. Roy Bird Cook

Doctor Cook was first appointed a member of the Board of Pharmacy on July 1, 1925, such appointment being made by the late Governor Howard M. Gore. He served as acting secretary of the Board until March 1932, when he became its full-time secretary, an office he still holds.

Doctor Cook has had a long and distinguished career in the affairs of his profession, both state and national. He was president of the West Virginia Pharmaceutical Association, 1918-19, and served as its secretary, 1923-26. He was chairman of the House of Delegates of the American Pharmaceutical Association, 1935-36, and president of the National Association of Boards of Pharmacy, 1938-39.

He received the Beal Award and the American Druggist Award in 1938 as "outstanding pharmacist in the state." That same year he was given the honorary degree of Doctor of Laws by West Virginia University for "outstanding contributions to American Pharmacy and American History."

Doctor Cook reached the pinnacle of his career from a national standpoint when he was elected and served as president of the American Pharmaceutical Association, 1942-43.

The Remington Medal was awarded to him in 1955 "in recognition of services to American pharmacy, nationally."

It is interesting to note that the West Virginia Board of Pharmacy, since its creation in the year 1900, has had but two secretaries, Doctor Cook and the late Alfred Walker of Sutton.

With the retirement of M. N. Ford of Ohio, Doctor Cook became the dean of secretaries of pharmacy boards, being the oldest in point of service in the United States.

The year 1960 will provide another opportunity for Doctor Cook to serve his profession nationally. As chairman of the American Pharmaceutical Association's Section on History of Pharmacy, he will preside at a meeting during the APA convention in Washington, D. C., August 15-19.

Much has already been said concerning the national reputation Doctor Cook has built up in the broad field of history, and his manuscripts and books on the subject are to be found in libraries throughout the world. He is known for his knowledge of the early history of West Virginia and is consulted frequently by both teachers and students statewide concerning events that transpired in the past.

As a member of an allied profession, Doctor Cook has a wide acquaintanceship among physicians. He is to be commended for his untiring efforts to cement relations between members of the medical and pharmaceutical professions. The close liaison between the two groups results largely from the work he has done in the past. His counsel is sought frequently in the matter of physician-pharmacist relations.

We extend congratulations to Doctor Cook upon his reappointment as a member of the State Board of Pharmacy. He has our best wishes for continued success.

## BELATED VINDICATION

Events are tending to vindicate the judgment of Dr. Richard J. Lilly, who was ousted as Director of the West Virginia Mental Health Department because a majority of the State Senate, and some other critics, felt he was too much concerned with the creature comforts of his charges and too little with advanced therapy.

Doctor Lilly took the position, which he maintained stoutly before the Senate, that the money available for his Department did not make possible both proper custodial care and the technical and professional improvements admittedly desirable. On the principle of first things first and a step at a time, Doctor Lilly undertook to assure first the comfort and cleanliness of the patients plus improvement of the premises in which they live with progress in the technical field left to the future as appropriations will permit.

Now the rejected Director's successor, Dr. Robert P. Hagerman, says he intends to continue, for the time being at least, Doctor Lilly's custodial care program which the Senate found so objectionable. The new Director has expressed, too, the opinion that Doctor Lilly's interest in custodial care was but part of an over-all program necessarily limited by lack of money with which to provide additional services and professional staff members. Occupational therapy and personal treatment, however desirable, demand a great deal more money, Doctor Hagerman points out, than is available at present.

The people of West Virginia have been awakened to the importance of improving our mental health program. Over a long period of years it was shamefully neglected, the neglect arising as much from public indifference as legislative preoccupation with other facets of state administration. Now that the need for improvement has been recognized, it seems reasonable to assume that future Legislatures, with public approval, will provide the necessary means. It is an unfortunate circumstance, however, that a man who saw the need, and who demonstrated the ability and disposition to make the most effective use of the means at his disposal, has been subjected to the unjust humiliation inflicted on Doctor Lilly because he couldn't work miracles and refused to permit patients to remain in physical discomfort while he went through the pretense of miracle making.—The Parkersburg News.

## 'INFORMED CONSENT'

A recent issue of *Medicolegal Digest* reports a rather disturbing decision by the Supreme Court of Kansas tending to increase very extensively the area of malpractice liability. In essence the principle laid down is that the physician must explain to a patient all the possible hazards of the treatment he plans before consent to the treatment is legal, and a physician may be liable for a bad result regardless of the fact that he had not been negligent, had followed accepted methods of treatment, and had exercised proper skill and care in his treatment.

In the case presented, a radiologist, after consultation, and with the patient's consent, had administered cobalt irradiation treatment to an area of the left chest wall from which a cancer of the breast had been removed by a radical mastectomy. Both the operating surgeon and the radiologist advised the cobalt treatment. With the patient's consent, the treatment was carried out and a rather extensive burn resulted. Both the radiologist and the hospital were sued, alleging negligence and further alleging neither she nor her husband was informed that there is always a calculated risk in cobalt administration.

The evidence submitted failed to sustain the charge of negligence in treatment and the jury found for the defendants. Motion for a new trial was denied, and the plaintiff appealed to the Supreme Court of Kansas, which, with two judges dissenting, ordered a new trial. In the order, the court said: "On retrial of this case the first issue for the jury to determine would be whether the administration of cobalt irradiation treatment was given with the informed consent of the patient, and if it was not, the physician who failed in his legal obligation is guilty of malpractice no matter how skillfully the treatment may have been administered, and the jury should determine the damages arising from the cobalt irradiation treatment. If the jury should find an informed consent was given by the patient for such treatment, the jury should next determine whether proper skill was used in administering the treatment."

We doubt seriously the wisdom of this decision. If all the states follow, and Missouri has, it will increase enormously malpractice litigation, already expanded beyond all reasonable bounds, and it may be very detrimental to an already apprehensive patient. We do feel that some emotionally stable member of the patient's family should be informed of the serious facets of any illness, but long and, at times, bitter experience has convinced us that great care should be

exercised in discussing all the possibilities faced by the actual patient himself. We believe the fact that doctors themselves are the hardest patients to treat satisfactorily results from their knowledge of the disease from which they suffer, its hazards and the possible complications.

Perhaps it is too much to expect state tribunals not to follow in the footsteps of the Federal Supreme Court which, semantically inclined, has stretched the definition of some words until they have cracked and practically exuded blood in the tension process. At any rate, the legal malpractice fence around us is one rail high now.

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**MAIL-ORDER PRESCRIPTION FILLING**

It is with sincere regret that we note the growth of mail-order prescription filling. The pharmacist is a legitimate and necessary member of the professional health team and the physician-patient relationship certainly overlaps into the physician-patient-pharmacist relationship. The best therapeutic results can be obtained only when patient confidence is assured, and that results best from personal contact of doctor, patient and pharmacist.

Probably the nidus of this nefarious mail-order business is the District of Columbia; certainly the practice is more advertised from there. We have information, however, that at least one other large city has two somewhat similar schemes, one of which sells memberships and offers cut-rate prescription filling to its members. As far as our information goes, these "drug stores" are not obvious as such to the passer-by, and at least one operates on an upper floor without any evidence at the street level of what goes on upstairs.

The Board of Trustees of the American Medical Association has investigated the practice and recommended to the House of Delegates at the Miami Beach Meeting that such practice be disapproved. Accordingly, the House of Delegates approved a resolution in which it was stated that "the unorthodox practice of mail-order filling of prescription drugs is not in the best interest of the patient except where unavoidable because of geographic isolation of the patient."

We heartily agree. The mail-order merchandising of prescription drugs disrupts the direct personal relationship which should exist between the patient-physician-pharmacist at the community level and which is essential to the public health and to the welfare of each individual patient. Moreover, it affords a possible cloak for substitution well-nigh impenetrable. On the other hand, assuming the honesty of the pharmacist, he is often unable to check upon the author of the prescription as to his honesty, ability, and professional standing. Such mail-order schemes should be frowned upon by the profession.

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### Man A Troubled Animal

Man is a troubled animal. In this day and generation, we are inclined to think of ourselves as being subject to more unsolved problems than have ever happened before. We are not at all sure of the past, the present faces us with many confusing decisions, and many look at the future with forboding. Every generation tends to think that it is peculiarly situated, that it has more trouble than any preceding generation, but I suspect that this is not true.

From the dawn of history, man has been troubled and he is rather inclined to think that his troubles are unique, never to have been met before, and presenting problems which are difficult, if not impossible, of solution. This worries many people, but it should not, because man is a living system and every living system is constantly trying to reach some kind of satisfactory adjustment to all the impulses that fall upon him during his lifetime. In one sense of the word, just the business of living is a struggle.—H. S. Burr, Ph.D., in Connecticut Medicine.

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### Compensation

One of the mechanisms all of us use is compensation. In everyday language, this means to pay or reward ourselves for something we have done. In Psychological language it refers to the way we make up for a lack of some specific ability. We unknowingly work very hard to develop an asset to substitute or "compensate" for some imaginary or real handicap.

Compensation is especially valuable to physically handicapped persons. For instance, a blind person develops with training an unusual sense of touch in his fingertips so that he can read the raised printing of Braille. The need to overcome such handicaps often results in real achievement and even fame. Milton, the blind English poet, had to have wires strung across his manuscript so that he could write in a straight line. He overcame his handicap to do what was then nearly impossible for a blind person to accomplish.

Whoever we are, we develop ways to find satisfactions that compensate for what we cannot do or have.—Warren C. Johnson, M. D., in Industrial Nurses Journal.

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### First Objective of Rehabilitation

The first objective of rehabilitation is to eliminate the physical disability if that is possible; the second, to reduce or alleviate the disability to the greatest extent possible; and the third, to retrain the person with a residual physical disability "to live and to work within the limits of his disability but to the hilt of his capabilities."—Howard A. Rusk, M. D., in Rhode Island Medical Journal.

# GENERAL NEWS

## Outstanding Program Arranged For Convention, Aug. 25-27

Dr. E. Vincent Askey of Los Angeles, California, president of the American Medical Association, heads a long list of prominent physicians and surgeons who will appear on the program at the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

Doctor Askey, who is a surgeon, was elevated to the presidency of the AMA at the annual meeting in Miami Beach in June. He is a past president of the Los Angeles County Medical Association and the California State Medical Association. He served for several years as Vice Speaker and Speaker of the AMA House of Delegates before being named president elect at the 1959 meeting in Atlantic City.

He will be the guest speaker before the second session of the House of Delegates on Saturday afternoon, August 27. His address will be heard shortly after the House convenes at 3:30 o'clock.

Another honor guest will be Dr. Charles B. Jolliffe, vice president and technical director of the Radio Corporation of America. He will deliver an address at the first general scientific session on Thursday morning, August 25. Doctor Jolliffe is a native of Mannington, West Virginia.

More than 800 persons, including physicians, their wives and guests, are expected to attend the three-day meeting at White Sulphur Springs.

The scientific sessions will feature a symposium on pyelonephritis, a program by the members of the faculty at the WVU School of Medicine in Morgantown, and papers of interest to all physicians on pediatrics, gynecology and obstetrics. Several of the guest speakers will also present papers before afternoon meetings of sections and affiliated associations and societies.

### Pre-Convention Meetings

The convention will not be formally opened until Thursday morning, August 25; however, several important committee meetings have been scheduled for Wednesday afternoon, August 24, and the pre-convention meeting of the Council will be held at 4 P. M.

The registration desk will be open from 2:30 to 4 o'clock on Wednesday afternoon, and from 8:30 to 9:30 that evening. The desk will be open on the main floor lobby from 8:30 A. M. to 5 P. M. daily thereafter during the convention.

### Presidential Address by Dr. J. C. Huffman

Dr. J. C. Huffman of Buckhannon, president of the West Virginia State Medical Association, will deliver his presidential address at the first session of the House of Delegates which will be held in the Fillmore and Van Buren Rooms on Wednesday evening, August 24, at 9 o'clock. He will preside at a business session which will follow his address.

### General Scientific Sessions in Theatre

All morning, afternoon and evening meetings in connection with the convention will be held in the air-conditioned convention unit of The Greenbrier.

General scientific sessions will be held in the Theatre on the registration floor level, directly under Chesapeake Hall where the scientific and industrial exhibits will be on display.

### Motion Pictures

Sound motion pictures on appropriate scientific subjects will be shown on Thursday, Friday and Saturday mornings prior to the opening of each general scien-

E. Vincent Askey, M. D.
AMA President

tific session. The chairman of the committee arranging the motion picture program during the meeting is Dr. Jules F. Langlet of Charles Town. (Elsewhere in *The Journal* will be found a news story outlining the motion picture schedule for the meeting).

**Formal Opening of Convention**
**Thursday Morning**

The convention will be called to order by Dr. Seigle W. Parks of Fairmont, chairman of the Program Committee, on Thursday morning, August 25, at 9 o'clock. The address of welcome will be delivered by Dr. J. C. Huffman of Buckhannon, president of the State Medical Association.

The first speaker on the program will be Dr. Charles B. Jolliffe, vice president and technical director of the Radio Corporation of America, whose subject will be "Electronics and Medicine."

The meeting will then be turned over to Dr. Kenneth G. MacDonald of Charleston, who will serve as moderator for a Symposium on Pyelonephritis. The panelists are as follows:

John W. Hash, M. D.
President Elect

Thomas A. Stamey, M. D., Associate Professor of Urology, The Johns Hopkins University Medical School, Baltimore, Maryland.

John B. Hazard, M. D., Chairman of the Division of Pathology and Head of the Department, Cleveland Clinic Foundation, Cleveland, Ohio.

George A. Wolf, Jr., M. D., Dean and Professor of Clinical Medicine, University of Vermont College of Medicine, Burlington, Vermont.

Each speaker will present a paper on the various aspects of pyelonephritis, after which there will be a panel discussion with a question and answer period. The speakers will also be asked to discuss several case presentations with protocols which will be mimeographed and distributed at the beginning of the session.

**Thursday Afternoon Program**

Dr. Albert C. Esposito of Huntington will preside at a meeting of the Resolutions Committee which will be held at 2 o'clock on Thursday afternoon.

An open meeting of the West Virginia State Society of Allergy will be held at 2 o'clock. Dr. Sarah L. C. Stevens of Huntington, president of the Society, will deliver an address of welcome and the moderator for the scientific session will be Dr. Merle S. Scherr of Charleston.

The guest speakers and their subjects are as follows:

"Single Annual Injection Treatment of Pollinosis."—Ethan Allan Brown, M. D., Boston, Massachusetts, Editor, *Annals of Allergy.*

"Respiratory Allergy with Negative Cutaneous Tests to Inhalant Allergens: Diagnosis and Treatment."—M. Murray Peshkin, M. D., New York City, Clinical Professor of Medicine and Pediatrics, Albert Einstein College of Medicine, Yeshiva University.

There will also be a panel discussion with full audience participation, and a demonstration of repository therapy or "single annual injection treatment of allergic diseases."

The West Virginia Chapter of the Medical College of Virginia Alumni Association will hold a business meeting and cocktail party at 5:30 o'clock. Dr. Charles M. Scott of Bluefield is in charge of arrangements.

Guests at the meeting will include Dr. Richard A. Michaux, president of the MCV Alumni Association; Dr. William F. Maloney, Dean, School of Medicine; and Mr. R. Reginald Rooke, immediate past president of the Alumni Association and president of the National Association of Retail Druggists.

**Second General Session**
**Friday Morning**

Dr. William A. Thornhill, Jr., of Charleston, will serve as moderator for the second general session beginning at 9:15 o'clock on Friday morning, August 26.

The program will be presented by members of the faculty of the new four-year School of Medicine at West Virginia University. Also appearing as speakers will be President Elvis J. Stahr, Jr., and Dr. Kenneth E. Penrod, vice president-medical affairs.

President Stahr will open the program with an address on the subject of "Your University." He will be followed by Doctor Penrod, whose subject will be "A Medical Center for the 60's."

Dr. Edmund B. Flink, Professor and Chairman of the Department of Medicine, and Dr. Bernard Zimmermann, Professor and Chairman of the Department of Surgery, will discuss "The Medical and Surgical Aspects of Hyperadrenalism."

Dr. Herbert E. Warden, Associate Professor of Surgery, will close the morning program with an

address on the subject of "Cardiac Aneurysms: Diagnosis and Surgical Treatment."

**Friday Afternoon Program**

Dr. Joseph H. Kite of Atlanta, Georgia, will present a paper before a meeting of the Section on Orthopedic Surgery which will be held at 2 o'clock on Friday afternoon. His subject will be "Congenital Metatarsus Varus Deformity." Dr. Maxwell H. Bloomberg of Elkins will preside.

"The Diagnosis of Curable Unilateral Renal Hypertension by Ureteral Catheterization" is the subject of a paper Dr. Thomas A. Stamey of Baltimore, Maryland, will present before a meeting of the Section on Urology at 2 o'clock. Dr. Paul L. McCuskey of Parkersburg will preside.

**Annual Meeting on E. S. T.**

The Greenbrier, at White Sulphur Springs, operates throughout the year on Eastern Standard Time, and EST will therefore be observed strictly in the schedule of all events in connection with the annual meeting of the West Virginia State Medical Association there, August 25-27, 1960.

Two guest speakers will appear on the program before a meeting of the Section on Internal Medicine at 2 o'clock. Dr. E. L. Crumpacker of White Sulphur Springs will preside and the speakers and their subjects are as follows:

"Metabolic Bone Diseases."—Edmund B. Flink, M. D., Morgantown, West Virginia.

"Use of Anticoagulants in Cerebral Vascular Disease."—George A. Wolf, Jr., Burlington, Vermont.

Dr. A. L. Wanner of Wheeling will preside at a business meeting of the Section on Neurology, Neurosurgery and Psychiatry which will be held at 2 o'clock.

Dr. Marion F. Jarrett of Charleston will preside at a business meeting of the West Virginia Diabetes Association at 3 o'clock, and Dr. Pat A. Tuckwiller of Charleston at a business meeting of the West Virginia Society of Internal Medicine at 3:30 o'clock.

**Final General Session**
**Saturday Morning**

Dr. G. Thomas Evans of Fairmont will serve as moderator at the third and final general scientific session beginning at 9:30 o'clock on Saturday morning, August 27. The guest speakers and their subjects are as follows:

"Pediatric Gynecology."—Roger B. Scott, M. D., Associate Professor of Obstetrics and Gynecology, Western Reserve University School of Medicine, Cleveland, Ohio.

"Anesthesia in the Complications of Pregnancy."—Vincent J. Collins, M. D., Associate Professor of Anesthesiology, New York University Medical Center, New York City.

"Problems of Adolescence."—Edward M. Litin, M. D., Consultant, Section of Psychiatry, Mayo Clinic, Rochester, Minnesota.

**Saturday Afternoon Meetings**

Dr. Gates J. Wayburn of Huntington will preside at a meeting of the West Virginia Obstetrical and Gynecological Society which will be held at 2 o'clock on Saturday afternoon. The guest speaker will be Dr. Roger B. Scott of Cleveland, Ohio, whose subject will be "The Correlation Between Psychology and Diagnostic Cervical Biopsy."

"Torsional Deformities of the Lower Extremities" will be the subject of a paper which Dr. Joseph H. Kite of Atlanta, Georgia, will present before a meeting of the Section on Orthopedic Surgery at 2 o'clock. Dr. Maxwell H. Bloomberg of Elkins will preside.

Two guest speakers will appear on the program before a meeting of the West Virginia Pediatric Society at 2 o'clock. Dr. W. W. Currence will preside. The speakers and their subjects are as follows:

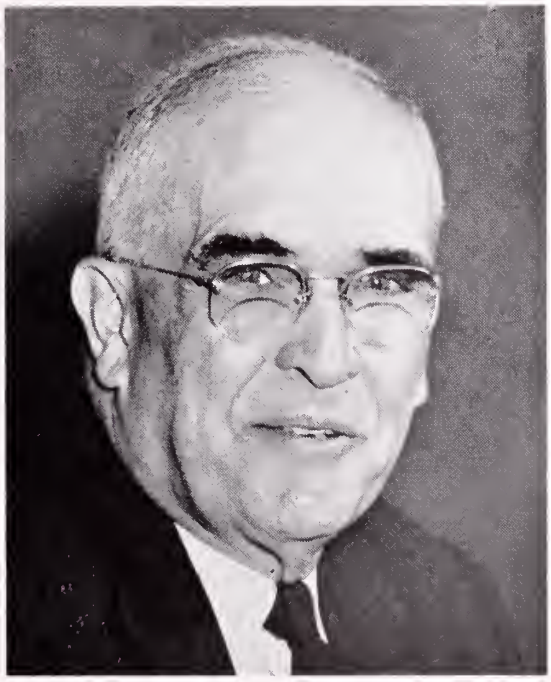
"Effects of Physical Handicaps on Personality Development in Children."—Edward M. Litin, M. D., Rochester, Minnesota.

"Pediatric and Adolescent Gynecology."—Roger B. Scott, M. D., Cleveland, Ohio.

There will be a business meeting with election of officers following the scientific program.

Dr. Bernard Zimmermann and Dr. Herbert E. Warden of the WVU School of Medicine in Morgantown will be the guest speakers before a meeting of the Section on Surgery at 2:15 o'clock. Dr. Charles E. Staats of Charleston will preside.

Dr. Logan W. Hovis of Parkersburg will preside at a meeting of the West Virginia Society of Anesthesio-



Charles B. Jolliffe, Ph. D.

logists which will be held at 2:30 o'clock. The guest speaker will be Dr. Vincent J. Collins of New York City, whose subject will be "Evaluation of Patients for Anesthesia."

### Second Session of House of Delegates

Dr. J. C. Huffman, the president, will preside at the second and final session of the House of Delegates which will be convened at 3:30 o'clock on Saturday afternoon.

Dr. John W. Hash of Charleston, the president elect, will be installed as president during the business session. Other officers for 1960-61 will also be elected and installed.

## Motion Picture Schedule

Dr. Jules F. Langlet of Charles Town, chairman of the motion picture program for the Annual Meeting at The Greenbrier, has announced that one film will be shown each morning just prior to the general scientific sessions. The starting times for the films will be 8:30 A. M.

The film on Thursday morning will be "Machine Mimics Man," which describes the operation of the artificial kidney. On Friday morning the film will be "Removal and Shipment of Eyes for Corneal Transplant." The film will be preceded by a short discussion by Dr. Ralph W. Ryan of Morgantown.

The film on Saturday morning will be "Improved Method of Repair of Imperforate Anus with Rectovaginal Fistula," which illustrates the improved method of placing the carefully freed rectum in its normal position behind the transverse perineal body.

Dr. E. Vincent Askey of Los Angeles, California, president of the American Medical Association, will be the guest speaker at this session of the House.

Harry G. Buchanan of Gilbert, Mingo County, the recipient of the 1960 four-year scholarship to the West Virginia University School of Medicine, will be introduced, together with Dr. Bernard S. Clements of Matoaka, who was named West Virginia's "General Practitioner of the Year."

### Dance on Friday Evening

The Woman's Auxiliary to the State Medical Association is in charge of the entertainment program at the Convention. The feature will be a dance in the Ballroom on Friday evening, with music by the Meyer Davis Orchestra.

### Cocktail Party on Saturday Evening

A Cocktail Party and Reception honoring the officers of the West Virginia State Medical Association will be held on the Chesapeake Hall Terrace on Saturday evening, August 27, from 6:30 to 7:30 o'clock. All members of the Association and Auxiliary, their families, representatives of the industrial exhibitors and guests are invited to attend.

Prizes to the winners of the Golf and the Skeet and Trap Shooting tournaments will be awarded at the cocktail party.

### Industrial and Scientific Exhibits

More than 60 interesting and informative scientific and industrial exhibits will be set up in Chesapeake Hall in the convention unit. There will also be exhibits in the foyer leading to the main lobby.

The exhibits will be open daily from 8:30 A. M. until 5 P. M. Physicians, members of the Auxiliary and guests are invited to visit and talk with the more than 100 representatives of various drug and accessory houses who will be present throughout the meeting.

## Dr. J. Howard Anderson Honored By Alma Mater

Dr. J. Howard Anderson of Welch, a graduate of Washington and Jefferson College, Class of 1895, was awarded the honorary degree of Doctor of Science by his alma mater during the 161st commencement exercises at Washington, Pennsylvania, early in June.

Doctor Anderson is a past president of the West Virginia State Medical Association and was elected in 1956 as West Virginia's "General Practitioner of the Year."

## House of Delegates To Meet Twice During Meeting

The Program Committee has announced that there will be two sessions of the House of Delegates during the Annual Meeting at The Greenbrier.

The first session will be convened at 9:00 o'clock on Wednesday evening, August 24, and the second session is scheduled for 3:30 o'clock on Saturday afternoon, August 27.

## Dr. Edith Cserny Named Superintendent Of Huntington State Hospital

Dr. Edith Cserny has been appointed superintendent of Huntington State Hospital. The appointment, announced by Dr. Robert P. Hagerman, director of the State Department of Mental Health, was effective July 18.

Doctor Cserny was appointed acting superintendent of the Institution in June, 1959. Previously, she had been serving as psychiatrist and member of the medical staff.

She attended elementary and high school in Hungary and Romania and received her M. D. degree from the University of Cluj Medical School in Romania in 1933. She came to the United States in 1949 and was naturalized in 1956. She was licensed to practice in West Virginia in January, 1957.

It is better to have a right destroyed than to abandon it because of fear.—Phil Mann.

## New Association Members

Dr. Chester D. Harman, 21 Central Avenue, Petersburg (Potomac Valley). Doctor Harman was born at Onego, West Virginia, and received his M. D. degree from the Medical College of Virginia in 1956. He interned at the Ohio Valley General Hospital in Wheeling, 1956-57, and then served for two years with the Medical Corps of the United States Army.

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Dr. Clay H. Orvis, The Golden Clinic, Elkins (Barbour-Randolph-Tucker). Doctor Orvis, a native of New York City, received his M. D. degree from New York Medical College in 1956. He interned at the UCLA Medical Center in Los Angeles, 1956-57, and served residencies at United Hospital and North Shore Hospital in New York City, 1957-59. His specialty is obstetrics and gynecology.

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Dr. Hassan Vaziri, 1216 Sixth Avenue, Huntington (Cabell). Doctor Vaziri, a native of Zanjan, Iran, received his medical training in that country and interned at St. John's Hospital, Long Island City, New York, 1949-50. He served a residency at that hospital and at the Bellevue Medical Center. He formerly was a member of the orthopedic staff at Morris Memorial Hospital in Milton.

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Dr. William R. Wolverton, 123 Tunnelton Street, Kingwood (Preston). Doctor Wolverton was born in Keyser and received his M. D. degree from the University of Maryland School of Medicine in 1952. He interned at Charleston General Hospital, 1952-53, and served a residency in general surgery at that hospital, 1953-54. He served residencies in orthopedic surgery at hospitals in Alabama, Tennessee and Arkansas, 1954-1959. He served for two years in the Medical Corps of the United States Army.

## Weekly TV Program for Physicians Scheduled for Fall Showing

"This Week in Medicine," a 15-minute, weekly open-circuit TV program is scheduled to be shown on a national 60-station network early this fall. The program will be broadcast about one o'clock on Sunday afternoons.

The program will be presented by the Editors of the newspaper, *Medical News*, under the sponsorship of Ciba Pharmaceutical Products. Although on open circuit, the program will be designed and intended exclusively for a physician audience.

The editorial content of "This Week in Medicine" will include five to six minutes of up-to-date world-wide news of medicine and medical science, plus a five to seven minute filmed feature report. The latter will deal with some current, significant aspect of clinical medicine, surgery and research.

## Advisory Board to Woman's Auxiliary Named by Doctor Hash

Dr. John W. Hash of Charleston, who will be installed as president of the West Virginia State Medical Association on the final day of the 93rd Annual Meeting at The Greenbrier, August 25-27, has appointed the following physicians as members of the Advisory Board to the Woman's Auxiliary:

Dr. J. C. Huffman, Buckhannon, chairman; and Drs. George F. Evans, Clarksburg; Buford W. McNeer, Hinton; John C. Condry, Charleston; and Clark K. Sleeth, Morgantown.

The members of the board will serve during the Auxiliary year, 1960-61.

**Representatives of the medical, dental, hospital and nursing home associations in West Virginia attended a meeting in Charleston on June 22 to discuss the possible formation of a Joint Council to Improve the Health Care of the Aged in West Virginia. Left to right, Dr. E. Lyle Gage of Bluefield, chairman of the State Medical Association's Committee on Aging, Mrs. Herman Conaway of Harrisville, Dr. Charles R. Singleton and J. Harold Laughlin, Charleston, Howard I. Wells, Jr., Executive Secretary of the National Joint Council, William R. Huff of Charleston, Daniel F. Berlin of Vienna, and Herman Conaway of Harrisville.**

## Council Hears Key Committee Report On Medical Care for the Aged

The whole field of medical care for the aged is being explored by the West Virginia State Medical Association. The matter is in charge of the Association's Medical Economics Committee which is working in conjunction with representatives of all of the Blue Shield Plans in West Virginia.

Dr. James S. Klumpp of Huntington, chairman of the committee, accompanied by Dr. John F. Morris, also of that city, chairman of a sub-group in charge of Blue Cross-Blue Shield matters, met with Blue Shield representatives in Parkersburg late in May, and the sole topic for discussion at that time was the formulation of a program that can be accepted by the medical profession and all of the Plans. It is hoped that some method can be devised by which our aging population, partciularly those 65 years of age and over, with limited incomes, can be provided with needed medical care.

An interim report was presented to the Council by Doctor Klumpp at the summer meeting held in Clarksburg on June 26. At that time it was agreed that a further report would be made at the pre-convention meeting at The Greenbrier on August 24.

### DPA Advisory Council

The Council was notified by Mr. Thomas R. Egbert, Director of the Department of Public Assistance, that he had set up an advisory council which is composed of Dr. L. Dale Simmons of Clarksburg, representing the medical profession; Dr. J. W. Dixon, Jr., of Charleston (Dental); Mr. Charles L. Showalter, Charleston, Administrator of Memorial Hospital in Charleston (Hospitals); Miss Juliann Ritter, Charleston, Executive Secretary of the West Virginia Nurses Association (Nursing Profession); Mr. Dewey J. Bailey, Princeton (DPA); and Dr. N. H. Dyer, Charleston, State Director of Health, ex officio.

### Doctor Van Liere Lauded

The Council went on record unanimously as approving the following resolution adopted by the WVU Liaison Committee at a meeting in Morgantown on May 26:

"WHEREAS, Dr. Edward J. Van Liere has for many years served as Dean of the West Virginia University School of Medicine and has won the esteem of all the members of the West Virginia State Medical Association; and,

"WHEREAS, Doctor Van Liere is relinquishing his official duties as Dean effective July 1, 1960, but will continue as a member of the faculty, serving as Professor of Physiology and continuing his research in that important field:

"NOW, THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association's WVU Liaison Committee go on record as commending Dean Van Liere for his long and useful service to the West Virginia University School of Medicine and to the members of the West Virginia State Medical Association; and,

"BE IT FURTHER RESOLVED, That we are deeply appreciative of his most worth-while endeavors in the promotion of medical education, medical research, and high ideals of the medical profession in West Virginia."

### AMEF Report

Doctor Klumpp read to the Council the annual report of the American Medical Education Foundation Committee, which the chairman, Dr. W. L. Neal of Huntington, prepared for publication in the August issue of *The Journal*. Accompanying the report was a resolution which will be offered by Doctor Neal at the first session of the House of Delegates on August 24, proposing that the annual dues of the State Medical Association be increased in an amount which will provide approximately $15,000 each year for the AMEF.

It was explained by Doctor Klumpp that Doctor Neal will at the proper time during the forthcoming meeting offer an amendment to the By-Laws providing for an increase in the annual dues of members from $35 to $45.

The matter was discussed by several members, and the Council then went on record as approving the resolution transmitted by Doctor Neal through Doctor Klumpp.

### Malnutrition in Children

The chairman, Dr. George F. Evans of Clarksburg, brought up the matter of statements that are frequently being made concerning malnutrition in children in West Virginia. He said that he had made a personal investigation in his part of the state, questioning several physicians, who report that they can find no increase in childhood conditions that can be traced to inadequate diet.

Doctor Dyer also discussed briefly a survey made recently by the State Department of Health with reference to child health conditions. He said that the survey showed a total of less than two hundred cases of malnutrition and that in his opinion conditions are no worse today than they were five years ago.

### Honorary Members

The following physicians were elected to honorary life membership in the State Medical Association:

| *Society* | *Physician* | *Address* |
|---|---|---|
| Cabell | William F. Beckner | Huntington |
| Mercer | P. R. Fox | Bluefield |
| Wyoming | Byron W. Steele | Mullens |

### Hopemont Resolution

Official notice was taken by the Council of the recent replacement by Governor Cecil H. Underwood of Dr. A. L. Starkey as superintendent of Hopemont Sanitarium.

Several members of the Council discussed the matter, speaking particularly of the long tenure of Doctor Starkey as superintendent, and the performance of excellent services by him as head of the institution.

The following resolution was unanimously adopted with the understanding that a copy was to be mailed to Governor Underwood at the Executive Offices in The Capitol:

"WHEREAS, Dr. A. L. Starkey, Superintendent of Hopemont Sanitarium, has been summarily dismissed by Governor Cecil H. Underwood without any hearing whatever; and,

"WHEREAS, Dr. A. L. Starkey has been a devoted, dedicated public servant at the Hopemont Sanitarium for 25 years, or his entire professional career; and,

"WHEREAS, Dr. A. L. Starkey is an outstanding authority in tuberculosis, and Hopemont Sanitarium has been a well run hospital for many years, and his loss by the state of West Virginia is irreparable:

"THEREFORE, BE IT RESOLVED, That the Council of the West Virginia State Medical Association notify Governor Underwood that our Association deeply regrets the dismissal of Doctor Starkey, and deplores the pernicious system that permits such unfair treatment, without any hearing, to a member of our profession in the service of our state institutions."

### Withdrawing Samples of Blood

The advisability of taking some action officially concerning the withdrawal by physicians of samples of blood for the purpose of determining alcoholic content in cases of alleged drunken driving was discussed by several members of the Council, but action was deferred pending further study and report by the Legislative Committee.

### Cooperation of Women's Clubs

Letters were read from Mrs. John F. McCuskey of Clarksburg, president of the West Virginia Federation of Women's Clubs, and Mrs. Paul P. Warden of Grafton, Chairman of that organization's health and welfare committee, expressing the desire and willingness of the organization, with 21,000 members, to cooperate with the State Medical Association in seeking passage by the Legislature of so-called health bills, particularly those drawn with the idea of providing means whereby our aged citizens may be afforded adequate medical care and hospitalization.

The members of the Council expressed interest in and appreciation of the offer of the representatives of the Federation, and it was ordered that letters of thanks be written to Mrs. McCuskey and Mrs. Warden with the assurance that the members of their group will be called upon if and when there is definite work to be done in the matter in which they have expressed interest.

### 'GP of the Year'

Late in the session, the Council named Dr. Bernard Sinclair Clements of Matoaka, Mercer County, as the State Medical Association's 1960 "General Practitioner of the Year" (Ed.: A separate news story appears elsewhere in this issue of *The Journal*).

Dr. George F. Evans of Clarksburg, chairman of the Council, presided at the meeting which was attended by Dr. Charles A. Hoffman of Huntington, councillor at large; Dr. J. C. Huffman of Buckhannon, president; Dr. John W. Hash of Charleston, president elect; Dr. D. E. Greeneltch of Wheeling, vice president; and Drs. Seigle W. Parks, Fairmont; Richard E. Flood, Weirton; S. Elizabeth McFetridge, Shepherdstown; J. C. Pickett, Morgantown; L. E. Neal, Clarksburg; Charles L. Goodhand, Parkersburg; L. J. Pace, Princeton; Harold Van Hoose, Man; William L. Cooke, Charleston; and Clyde A. Smith, Beckley; and Mr. Charles Lively, executive secretary, and Mr. William H. Lively, executive assistant.

The meeting was also attended by Dr. James S. Klumpp, chairman of the medical economics committee, and Dr. Walter E. Vest, Editor of *The Journal*, both of Huntington; Dr. N. H. Dyer of Charleston, state director of health; Dr. John D. H. Wilson, Clarksburg, member of the medical economics sub-group on DPA-Workmen's Compensation; Dr. Richard W. Corbitt of Parkersburg, chairman of the public service committee; and Dr. L. Dale Simmons of Clarksburg, member of the DPA medical services advisory council.

The pre-convention meeting of the Council will be held at The Greenbrier in White Sulphur Springs on Wednesday afternoon, August 24, at four o'clock.

## Dr. Litsinger New Superintendent Of Spencer State Hospital

Dr. Edward A. Litsinger, formerly of Charleston, has been appointed by Governor Cecil H. Underwood as superintendent of Spencer State Hospital. The appointment was effective July 1, 1960. He has served as acting superintendent since April 1, 1959, succeeding Dr. Isaac East.

Doctor Litsinger engaged in private practice in Charleston until 1958, when he accepted appointment as a member of the medical staff at Weston State Hospital, a position he held until accepting appointment as acting superintendent at Spencer.

## Dr. Huffman Named Upshur Health Officer

Dr. J. C. Huffman of Buckhannon has been appointed part-time health officer for Upshur County. He succeeds Dr. Emma Jane Freeman of that city, who was recently appointed director of the division of maternal and child health of the State Department of Health.

## Add Life to Years

In a youth-oriented country, where approaching old age most often leads—not to contemplation, but to a face lift—there is a growing interest at the "grass roots" level in the program of the aged.

This is exactly where it should be, since every living person begins aging from the day of his birth.

I like to think that here in America, care for the older, perhaps disabled, members of a family is a personal privilege and project for the stronger and younger members of the family. In most families, if this is sometimes a burdensome or distasteful service, few outsiders ever know it. Unfortunately, today there are those who think care of aged or disabled persons is a burden and a responsibility which should be shifted entirely to a state or national government.

Time, it must be admitted, does not stand still even for the physician. Our profession is largely responsible for the years which have been added to the average American's life span; and the responsibility for helping to make these years rich and good is also surely ours—in part.—May Owen, M. D., in Texas State Journal of Medicine.

## Dr. Leonard W. Larson, Bismarck, N. D., Named AMA President Elect

Dr. Leonard W. Larson of Bismarck, North Dakota, was named president elect of the American Medical Association at the annual meeting in Miami Beach, June 13-17. He was elected by the unanimous vote of the members of the House of Delegates at the concluding session at the Americana Hotel on June 16.

Doctor Larson will succeed Dr. E. Vincent Askey of Los Angeles, who was installed as president on Tuesday evening, June 14.

Dr. William F. Costello of Dover, New Jersey, was elected vice president to succeed Dr. J. Stanley Kenney of New York City. Dr. Norman E. Welch of Boston was reelected speaker of the House of Delegates, and Dr. Milford O. Rouse, of Dallas, Texas, was renamed vice speaker.

One new trustee was elected and one reelected at the session on June 16. Dr. Gerald D. Dorman of New York City was named a member of the board to fill the vacancy created by the election of Doctor Larson as president elect, and Dr. James E. Appel of Lancaster, Pennsylvania, was reelected a member. He has been serving on the board since 1957.

### Dr. Julian Price Board Chairman

Dr. Julian Price of Florence, South Carolina, well known to physicians in West Virginia, was elected chairman of the Board of Trustees to succeed Doctor Larson.

The registration through Thursday, June 16, totaled 19,107, including 8,076 physicians and 11,031 guests.

At the Atlantic City meeting last year, the physician registration through Thursday totaled 12,921, and guests, 15,034, for a grand total of 28,225.

### Clinical Meeting in Washington, D. C.

The 1960 Clinical meeting of the AMA will be held in Washington, D. C., November 28-December 1.

Scientific and industrial exhibits will be set up in the Armory, and headquarters will be maintained at the Sheraton-Park Hotel. The 1960 "General Practitioner of the Year" will be named during the meeting.

It was announced that the 1961 Clinical meeting will be held in Denver, November 27-30, and other meetings were scheduled as follows:

### AMA Meetings, 1961-65

1962 Annual Meeting, Chicago, June 11-15; 1962 Clinical Meeting; Los Angeles, November 25-29; 1963 Annual Meeting, Atlantic City; 1964 Annual Meeting, San Francisco; 1965 Annual Meeting, New York City.

## Dr. Villani Renamed to State PN Board

Dr. A. J. Villani of Welch has been reappointed by Governor Cecil H. Underwood as a member of the State Board of Examiners for Practical Nurses. The reappointment is for a term of five years, effective July 1, 1960.

## Doctor Holroyd Reelected Secretary Of Aces and Deuces

Dr. Frank J. Holroyd of Princeton, one of the two AMA delegates from West Virginia, was reelected secretary-treasurer of the Aces and Deuces organization at the annual breakfast meeting of the group held at the Americana Hotel in Miami Beach on June 14. The meeting was attended by more than 150 persons.

Dr. Charles J. Ashworth of Providence, Rhode Island, was elected president, succeeding Dr. Wesley W. Hall of Reno, Nevada. Dr. Walter E. Vest of Huntington, a past president, served as chairman of the nominating committee.

Also attending the breakfast meeting were Mrs. Holroyd, Dr. and Mrs. J. C. Huffman of Buckhannon, and Dr. Charles A. Hoffman of Huntington. Doctor Hoffman is an AMA delegate and Doctor Huffman serves as an alternate.

The Aces and Deuces is a social organization composed of AMA delegates and alternates from State Medical Associations and Societies which have one or two members in the House of Delegates.

An Aces and Deuces luncheon honoring AMA officers and members of the House of Delegates will be held during the Clinical Session in Washington, D. C., in December.

## James Barnes of North Carolina Installed as Head of MSEA

The annual business meeting of the Medical Society Executives Association was held at the Americana Hotel in Miami Beach, on Saturday afternoon, June 11, with the president, Tom Hendricks, of Chicago, assistant to the executive vice president of the American Medical Association, presiding.

The group named Fred Fagler of Pittsburgh, executive secretary of the Allegheny County Medical Society, as vice president and president elect, and he will be installed at the annual meeting in New York City in June, 1961. John C. Foster of Sioux Falls, S. D., executive secretary of the South Dakota Medical Association, was elected secretary-treasurer.

Named to the executive board were C. Lincoln Williston, executive secretary of the Texas Medical Association, and Joseph C. Conovan, executive secretary of the Santa Clara County Medical Society, San Jose, California.

At the close of the afternoon session, James Barnes, executive secretary of the Medical Society of the State of North Carolina, was installed as president by the retiring president, Tom Hendricks.

The guest speaker at the banquet in the evening was Herb Shriner, veteran television and motion picture star. He was introduced by Tom Hendricks.

John M. Hanni, Jr., of Miami, executive secretary of the Dade County Medical Association, was chairman of the local arrangements committee.

## Major Policy Matters Acted Upon By AMA at Annual Meeting

Dr. Charles A. Hoffman of Huntington and Dr. Frank J. Holroyd of Princeton, AMA Delegates, headed the West Virginia delegation at the 109th Annual Meeting of the American Medical Association in Miami Beach, June 13-17. Other officers of the Association present were Dr. J. C. Huffman of Buckhannon, President; Dr. John W. Hash of Charleston, President Elect; Dr. George F. Evans of Clarksburg, Chairman of the Council; and Dr. Walter E. Vest of Huntington, Editor of *The Journal*.

Doctor Vest is a member of the AMA Council on Constitution and By-Laws, and attended meetings held before and during the convention.

No attempt was made by the AMA to compile a list by states of members attending this year's meeting. At former meetings, the names of members registering on the last day have been inadvertently omitted from published lists, so except for figures concerning registration no information was included in issues of the Daily Bulletin concerning delegates and guests present from the various states and foreign countries.

All of the officers of the American Medical Association, delegates and alternates, and administrative personnel of state medical associations were housed in the Americana, the headquarters hotel for the convention.

The widest possible publicity was given to the proceedings of the House of Delegates. Representatives of news media, including press, radio and television, were in Miami Beach in great numbers, and the AMA Publicity Department, headed by John Bach, released interesting and informative news stories at frequent intervals throughout the meeting.

The following summary of the Miami Beach meeting was prepared for publication by Dr. F. J. L. Blasingame, executive vice president of the American Medical Association:

Health care for the aged, pharmaceutical issues, occupational health programs, and relations with allied health groups were among the major subjects involved in policy actions by the House of Delegates at the American Medical Association's 109th Annual Meeting held June 13-17 in Miami Beach.

Dr. Charles A. Doan, who retired July 1 as dean of the Ohio State University College of Medicine and Director of the Health Center in Columbus, received the American Medical Association's 1960 Distinguished Service Award, one of medicine's highest honors. The Award is given annually to a physician who has "made a valuable contribution to the advancement of medical science." (Ed: Doctor Doan, who has hundreds of friends in West Virginia, has appeared several times as guest speaker before annual meetings of the State Medical Association).

### Health Care For The Aged

After considering a variety of reports, resolutions and comments on the subject of health care for the aged, the House of Delegates adopted the following statement as official policy of the American Medical Association:

"Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and then only in conjunction with the other levels of government, in the above order. The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept and is not inconsistent with previous actions of the House of Delegates of the American Medical Association."

The House also urged the Board of Trustees "to initiate a nonpartisan open assembly to which all interested representative groups are invited for the purpose of developing the specifics of a sound approach to the health service and facilities needed by the aged, and that thereafter the American Medical Association present its findings and positive principles to the people."

In connection with an educational program regarding the aged, the House declared that "the American Medical Association increase its educational program regarding employment of those over 65, emphasizing voluntary, gradual and individualized retirement, thereby giving these individuals not only the right to work but the right to live in a free society with dignity and pride."

Earlier, at the opening session, Dr. Louis M. Orr, retiring AMA president, had asked the House to go on record favoring more jobs for the aged, voluntary retirement and a campaign against discrimination because of age, whether it be 40 or 65. The House also gave wholehearted approval to Doctor Askey's urging that state medical societies take an active part in state conferences and other planning activities preceding the January, 1961, White House Conference on Aging.

### Pharmaceutical Issues

In the pharmaceutical area the House took two actions, one regarding mail order drug houses and the other involving the development and marketing of pharmaceutical products.

The House agreed with representatives of the pharmacy profession that the unorthodox practice of mail order filling of prescription drugs is not in the best interest of the patient, except where unavoidable because of geographic isolation of the patient. The statement emphasized the fact that in this process the direct personal relationship which exists between the patient-physician-pharmacist at the community level and which is essential to the public health and the welfare of patients, is lost.

The House also directed the Board of Trustees to request the Council on Drugs and other appropriate

Association councils and committees "to study the pharmaceutical field in its relationship to medicine and the public, to correlate available material, and after consultation with the several branches of clinical medicine, clinical research, and medical education and other interested groups or agencies, submit an objective appraisal to the House of Delegates in June, 1961." It was pointed out that certain proposals have been made which, if carried out, might impair the future of pharmaceutical research and development, thus retarding the progress of scientific therapy. It also said that the services of the pharmaceutical industry are so vital to the public and to the medical profession that an objective study should be made.

### Occupational Health Programs

The House approved a revised statement on the "Scope, Objectives and Functions of Occupational Health Programs," which was originally adopted in June, 1957. The new statement contains no fundamental alterations in AMA policy or ethical relationships, but it adds important new material on the following points:

1. Greater emphasis on the preventive and health maintenance concepts of occupational health programs.
2. A more positive statement of organized medicine's obligations to provide leadership in improving occupational health services by part-time physicians in small industry.
3. Increased emphasis on rehabilitation of the occupationally ill and injured.
4. Inclusion of the proper use of immunization procedures for employes, as approved by the House in 1959.
5. A more adequate statement on the need for teamwork with lay industrial hygienists in tailoring each occupational health program to the particular employe group involved.

In approving the revised guides for occupational health programs, the House also accepted a suggestion that the AMA Council on Occupational Health undertake a project to study and encourage the employment of the physically handicapped.

### Allied Health Groups

The House approved the final report of the Committee to Study the Relationships of Medicine with Allied Health Professions and Services and commended it as "a monumental work." The report covers the present situation, future implications and recommendations, including guiding principles and approaches to activate physician leadership. The House strongly recommended that AMA activity in this vitally important area be continued and it approved the appointment of a Board of Trustees committee to carry on the work.

### National Foundation

The House took action involving relations between the medical profession and the National Foundation. It adopted a statement of policies for the guidance of state medical associations and recommended that they be adopted by all component medical societies. These policies cover such subjects as membership of medical advisory committees at the chapter level, the function of these committees, and basic principles concerning financial assistance for medical care, payment for physicians' services and physicians' responsibilities for constructive leadership in medical advisory activities.

In another action the House directed the Board of Trustees to authorize further conferences with leaders in the National Foundation on the problem of poliomyelitis as it relates to the betterment of the public health and to consider further joint action toward the eradication of polio. The House commended the National Foundation for its outstanding service in the attack against polio, but pointed out that much work remains to be done in public education, vaccination, continuing assistance for polio victims and continued research.

### Miscellaneous Actions

In dealing with reports and resolutions on a wide variety of other subjects the House also:

Strongly reaffirmed its support of the Blue Shield concept in voluntary health insurance and approved specific recommendations concerning AMA-Blue Shield relationships;

Approved a contingent appointment of not more than six months for foreign medical school graduates who have been accepted for the September, 1960, qualification examination;

Urged individual members of the Association to take a greater interest and more active part in public affairs on all levels;

Reaffirmed its opposition to compulsory inclusion of physicians under Title II of the Social Security Act and recommended immediate action by all AMA members who agree with that position;

Urged reform of the federal tax structure so as to return to the states and their political subdivisions their traditional revenue sources;

Directed the Board of Trustees to develop group annuity and group disability insurance programs for Association members; and

Expressed grave concern over the indiscriminate use of contact lenses.

### Addresses and Awards

Doctor Orr, in his final report to the House at the opening session, urged medical societies to "adopt" rural villages, cities and regions in underdeveloped parts of the world and to send them medical, clinical and hospital supplies.

Doctor Askey, in his inaugural address Tuesday night, declared that medicine faces its greatest challenge in the decade ahead, adding that physicians must prove the effectiveness of medicine practiced in a free society. John S. Millis, Ph.D., president of Western Reserve University, Cleveland, Ohio, and guest speaker at the inaugural ceremonies, said the human dilemma of the sixties is an increasing desire for security and authority with a diminishing desire for responsibility.

At the Wednesday session of the House, Doctor Askey urged intensified accelerated effort in five areas, medical education, preparations for the White House Conference on Aging next January, health insurance

and third party relationships, mental health, and membership relations.

The Goldberger Award in Nutrition was presented to Dr. Richard Vilter of the University of Cincinnati. The Boy Scouts of America, celebrating its golden jubilee, presented the AMA with a citation in appreciation of the medical profession's help and support. Dr. B. E. Pickett of Carrizo Springs, Texas, retiring chairman of the Council on Constitution and Bylaws, received an award in recognition of his long service.

## Mrs. Charles L. Goodhand Elected Treasurer of AMA Auxiliary

Mrs. Charles L. Goodhand of Parkersburg was elected treasurer of the Woman's Auxiliary to the American Medical Association at the 37th Annual Meeting in Miami Beach, Florida, June 11-15, 1960. She succeeds Mrs. Harlan English of Danville, Illinois, who was named president elect.

Mrs. Charles L Goodhand

Mrs. Goodhand has just completed a term as first vice president of the AMA Auxiliary. She had previously served five consecutive terms as legislation chairman. She has always been active in Auxiliary affairs, both state and national, and is a past president of the Auxiliary to the West Virginia State Medical Association.

Mrs. William Mackersie of Detroit, Michigan, was installed as president during the meeting in Miami Beach. She succeeds Mrs. Frank Gastineau of Indianapolis, Indiana.

First vice president, Mrs. William G. Thuss, Alabama; regional vice presidents, Mrs. Hannibal Hamlin, Rhode Island (Eastern), Mrs. C. Rodney Stoltz, South Dakota (North Central), Mrs. W. W. Hubbard, Tennessee (Southern), and Mrs. Hiram D. Cochran, Arizona (Western); constitutional secretary, Mrs. T. A. Poska of California; and directors, Mrs. David C. Boyer of Colorado, Mrs. Robert D. Croom, Jr. of North Carolina, and Mrs. Richard C. Bellamy of Texas.

At a luncheon honoring national past presidents, the Auxiliary presented a check for $170,230 to the AMEF.

The Auxiliary to the Tennessee State Medical Association was awarded the "Ethel Gastineau Trophy" for outstanding efforts in behalf of the AMEF. The trophy, presented last fall to Mrs. Gastineau for her continuing work with the AMEF, was established by her as a "traveling trophy" to be awarded annually.

The registration for the four-day meeting was 2,202. The 38th Annual meeting will be held in New York City, June 26-30, 1961, conjointly with the annual meeting of the American Medical Association.

## Health Care of the Aged Debated Before Conference of Presidents

The 16th Annual meeting of the Conference of Presidents and other Officers of State Medical Associations, which was held at the Americana Hotel in Bal Harbour, Miami Beach, Florida, Sunday, June 12, featured addresses by prominent professional and lay speakers, including the chairmen of the Democratic and Republican National Committees.

Honorable Paul M. Butler, chairman of the Democratic National Committee, predicted that the delegates to the convention in Los Angeles would endorse a policy plank calling for approval of the controversial Forand bill. Senator Thruston B. Morton, GOP National Chairman, asserted that his party is flatly opposed to any compulsory approach as embodied in the Forand measure.

Both speakers agreed that the issue will be a major one in the presidential campaign this year.

Another speaker, Honorable Ross Barnett, Governor of Mississippi, whose subject was "What is Our Heritage?", said that the states, and not the federal government, should look after the health care of needy elderly persons. A handful of "power mad and greedy politicians," he said, are pushing "socialized medicine" in an effort "to dictate our every action from Washington."

Dr. Gilson Colby Engel, of Philadelphia, president of the Conference, presided at the meeting which was opened with an address by the president elect, Dr. Donald C. Conzett, of Dubuque, Iowa.

A social hour followed the half-day session, with Dr. Theodore G. Klumpp, president of Winthrop Laboratories of New York City, as the host.

### No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27, 1960.

## Interstate PG Scientific Assembly In Pittsburgh, Oct. 31-Nov. 3

The 45th Scientific Assembly of the Interstate Postgraduate Medical Association will be held at the Pittsburgh Hilton Hotel in Pittsburgh, October 31-November 3, 1960.

This postgraduate medical teaching program is presented annually by the Interstate Postgraduate Medical Association of North America.

The advance registration fee is $10.00, and the program provides Category I Credit for members of the American Academy of General Practice.

A copy of the complete program may be obtained by writing to Interstate Postgraduate Medical Association, Box 1109, Madison 1, Wisconsin.

## Doctor Milam Accepts Appointment At WVU School of Medicine

Dr. D. Franklin Milam, Chief of Urology at Charleston General Hospital since 1957, has accepted appointment as Associate Professor of Surgery and Chairman of the Division of Urology at the West Virginia University School of Medicine. The appointment was announced late in June by University President Elvis J. Stahr, Jr.

A native of Sissonville, West Virginia, Doctor Milam was graduated from West Virginia University in 1942 and from the two-year School of Medicine in 1943. He received his M. D. degree from the University of Pennsylvania School of Medicine in 1944.

He served his internship at the University of Pennsylvania Hospital in Philadelphia, 1944-45, and then

D. Franklin Milam, M. D.

served as Bishop Matthews Fellow in Urology at that hospital, 1945-46.

In 1946, Doctor Milam was called to active duty with the Medical Corps, AUS. He served as Chief of Urologic Service at Fort Monmouth Station Hospital, Fort Monmouth, New Jersey, and at the 50th United States Field Hospital in Paris, France. He was discharged in 1948 with the rank of Captain.

He returned to the University of Pennsylvania Hospital where he served as assistant resident and assistant instructor in urology, 1948-49. During the next year he served as senior resident and instructor in urology.

Doctor Milam accepted appointment in 1950 as a member of the faculty at Creighton University School of Medicine in Omaha, Nebraska. He remained there until 1954, at which time he located in Charleston for the practice of his specialty of urology.

He is a Diplomate of the American Board of Urology and a member of Phi Beta Kappa, Kanawha Medical Society, West Virginia State Medical Association and the American Medical Association. He is also a member of the Mid Atlantic Section, American Urological Association, American Geriatrics Society and the Southern Medical Association.

He is married and the father of one child.

## Medical Golf Tournament At The Greenbrier

Dr. Joseph T. Mallamo of Fairmont will attempt to retire the championship trophy during the annual Medical Golf Tournament which will be held in connection with the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

He has won two legs on the beautiful trophy offered by the Hospital and Physicians Supply Company of Charleston. The physician who wins the tournament three times wins permanent possession of the trophy.

Physicians participating will pay an entrance fee of $5, payable at the time they register for play in the tournament. There will be several prizes in addition to the championship trophy.

Instead of play being restricted to afternoons as in the past, participants may engage in tournament play both mornings and afternoons during the three-day meeting. Physicians are to inform the starter when they begin their official tournament round. All tournament play must be completed by 4 o'clock on Saturday afternoon, August 27.

The tournament will be set up in different flights, according to the number of players. Prizes to winners in the various flights will be awarded at the Cocktail Party on Saturday evening.

Doctor Mallamo is chairman of the golf committee and the other members are Drs. Robert S. Wilson of Clarksburg and George A Curry of Morgantown.

## Dr. Charles A Zeller Named Head Of Weston State Hospital

Dr. Charles A. Zeller, chief of psychiatry at Southwestern State Hospital at Marion, Virginia, since July 1, 1958, has been named superintendent of Weston State Hospital to succeed Dr. R. P. Hagerman, who resigned to accept appointment as Director of the Department of Mental Health. The appointment was announced by Doctor Hagerman, effective as of June 15, 1960.

Doctor Zeller served as superintendent of Weston State Hospital from 1949 until 1951, when he resigned to accept appointment as chief psychiatrist at the VA Hospital in Clarksburg, a post he held until accepting appointment at the Virginia institution in 1958.

## New Staff Appointments Announced By WVU School of Medicine

The appointment of Dr. William G. Klingberg of St. Louis, Missouri, as Professor and Head of the Department of Pediatrics at the West Virginia University School of Medicine was announced recently by President Elvis J. Stahr, Jr. He will assume his duties at the Medical Center on September 1.

Wm. G. Klingberg, M. D.

Doctor Klingberg, who is currently serving as Associate Professor of Pediatrics at Washington University School of Medicine, was graduated from Municipal University of Wichita, Kansas, and received his M. D. degree from Washington University School of Medicine.

He served an internship and had residency training at St. Louis Children's Hospital, where he is now associate physician. He also is a consultant in pediatrics for the medical schools of the Universities of Missouri and Illinois. During 1957-58, he served as visiting professor at the Ankara (Turkey) University School of Medicine.

Doctor Klingberg is certified by the American Board of Pediatrics and is a member of the American Academy of Pediatrics. He is active in research and is the author and co-author of a number of articles and abstracts which have appeared in professional journals.

### New Assistant Professor of Pathology

The other appointment announced was that of Dr. Edward G. Stuart of Philadelphia as Assistant Professor of Pathology. He has been serving on the faculty at the University of Virginia School of Medicine.

Doctor Stuart received his M. D. degree from Duke University School of Medicine and a Ph.D. degree from the University of Pennsylvania School of Medicine. He served a residency in neuropathology at Duke.

He is the author of several abstracts and articles on such subjects as connective tissue alterations, wound healing and spinal cord regeneration. Currently, he is writing a textbook on pathology.

## Medical Meetings, 1960

The following is a partial list of national, state and district medical meetings scheduled for 1960:

**Aug. 25-27—93rd Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.**
Sept. 13-15—National Cancer Conf., Minneapolis.
Sept. 16—W. Va. Heart. Assn., Parkersburg.
Sept. 22-24—W. Va. Hospital Assn., White Sul. Springs.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 9-14——Am. Acad. Oph. and Otol., Chicago.
Oct. 10-14—ACS, San Francisco.
Oct. 17-20—Am. Acad. Pediatrics, Chicago.
Oct. 21-23—PG Institute, Martinsburg.
Oct. 21-25—Am. Heart Assn., St. Louis.
Oct. 31-Nov. 3—Southern Medical, St. Louis.

## Skeet and Trap Shooting Tournament During the Annual Meeting

The Greenbrier Gun Club on Kate's Mountain will be the scene of the Skeet and Trap Shooting Tournament which will be held in connection with the 93rd Annual Meeting of the State Medical Association at The Greenbrier, August 25-27.

Dr. T. P. Mantz of Charleston is in charge of the tournament this year and the other members of the committee are Drs. J. L. Patterson of Logan and Albert C. Esposito of Huntington.

Dr. Francis L. Coffey of Huntington is the defending champion, having won permanent possession of the championship trophy after winning a third leg during the meeting in 1959. A new trophy will be offered by the Medical Arts Supply Company of Huntington.

Smaller trophies will be awarded to winners in the various classes of the tournament, which will be held during the three-day meeting.

Doctor Mantz has requested physicians who expect to enter the tournament to communicate with him prior to the meeting so that he may be sure to have sufficient professional help on hand each day. His address is 601 Atlas Building, Charleston.

### Proposed Constitutional Amendment

The following amendment to the Constitution of the West Virginia State Medical Association offered at the 92nd Annual Meeting at The Greenbrier in White Sulphur Springs, August 20-22, 1959, by James S. Klumpp, M. D., of Huntington, Chairman of the Committee on Constitution and By-Laws, will be acted upon finally by the House of Delegates at the 93rd Annual Meeting at The Greenbrier, August 25-27, 1960:

**Art. V**

Sec. 1. Amend the section by adding at the end thereof the following: "and (4) one delegate from each section and affiliated association and society which has been accepted and approved by the Council."

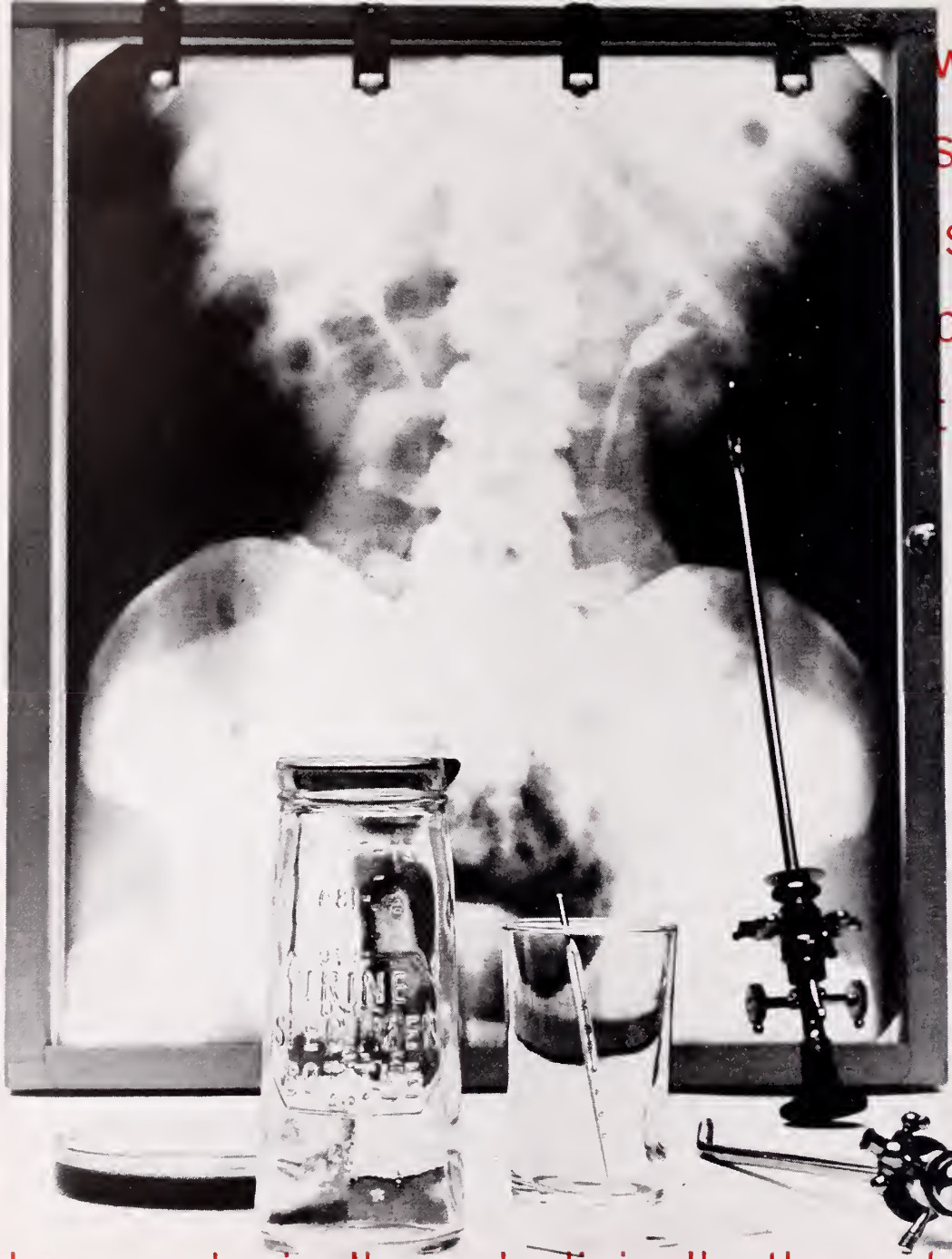
(The effect of the amendment would be to expand the membership in the House of Delegates so as to include a delegate from each Council-approved section and affiliated association and society).

## Civil Defense Council Conference

The Ninth Annual Conference of the Medical-Health Section of the United States Civil Defense Council will be held at the Leamington Hotel in Minneapolis, Minnesota, September 21-22, 1960.

An impressive program has been arranged by the Chairman, Dr. Carroll P. Hungate for the two-day meeting. Several physicians prominent in civil defense will present papers.

At the citation banquet on the evening of September 22, outstanding personalities in the field of Civil Defense and Disaster preparedness will be honored.



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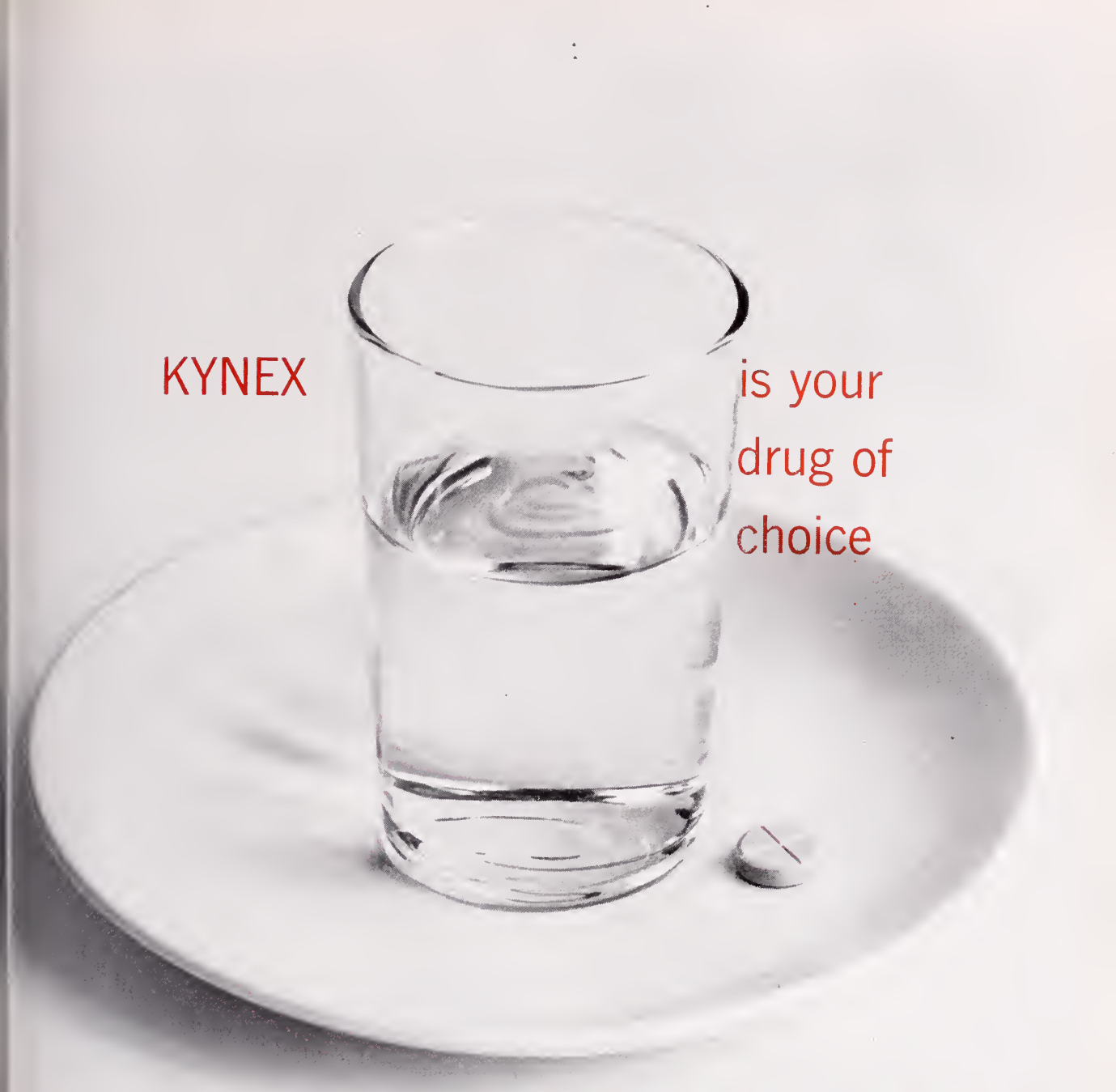
1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.





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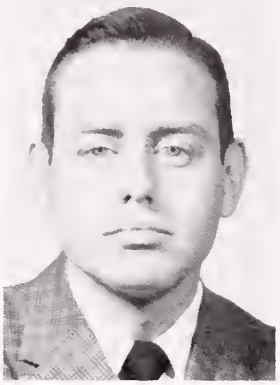
## Dr. Richard E. Jones Named Head Of WVU Anesthesiology Dept.

Dr. Richard E. Jones of Swarthmore, Pennsylvania, has been appointed professor and chairman of the Division of Anesthesiology at the West Virginia University School of Medicine. The appointment was announced by President Elvis J. Stahr, Jr.



Richard E. Jones, M. D.

Doctor Jones, a native of Cincinnati, Ohio, has been a member of the faculty of the University of Pennsylvania School of Medicine since 1953. He also has served as attending consultant in anesthesiology at the VA Hospital in Philadelphia.

He was graduated from Ohio State University and received his M. D. degree from the Ohio State University College of Medicine in 1950. He interned at the City of Detroit Receiving Hospital and then served with the Medical Corps of the United States Army in Korea.

Doctor Jones is a Diplomate of the American Board of Anesthesiology and a member of the Philadelphia Physiological Society.

## Annual Clinical Congress of ACS In San Francisco, Oct. 10-14

The 46th Annual Clinical Congress of the American College of Surgeons will be held in San Francisco, October 10-14, 1960.

It is expected that more than 10,000 physicians will attend the sessions, including many from foreign countries. There will be more than a thousand participants, including authors of research reports, teachers of postgraduate courses, participants in panel discussions, lecturers, and operating surgeons in motion pictures and closed circuit telecasts.

Addresses will be presented by Dr. I. S. Ravdin, Philadelphia, chairman, Board of Regents, and incoming president of the College; Dr. Joseph Trueta, Oxford, England, who will speak on trauma and the living cell; Dr. Wendell M. Stanley, director of the virus laboratory at the University of California, Berkeley, and Nobel winner in chemistry, who will deliver the Martin Memorial Lecture, named for the College founder, Franklin H. Martin. His subject will be "Virus-Cancer Relationships." Mr. Leslie P. Le Quesne, London, England, will give the annual Baxter Lecture, his subject being "Body Fluid Disturbances Resulting from Stomach Obstruction."

On the final evening, October 14, initiates will be presented for fellowship, honorary fellowships conferred, and officers installed.

## American Trudeau Society Becomes American Thoracic Society

The medical section of the National Tuberculosis Association has changed its name from the American Trudeau Society to the American Thoracic Society. The change in name was announced by James E. Perkins, M. D., NTA managing director.

The new name, Dr. Perkins pointed out, reflects more accurately the broad interest of the membership in all diseases of the chest and respiratory tract, as well as tuberculosis. "It seemed that the time had come," said Dr. Perkins, "for the name of the ATS to reflect the current scientific interests of the membership, reluctant as it was to relinquish the name of Dr. Edward L. Trudeau, the great physician who pioneered in the treatment and research of tuberculosis, and who was the first president of the National Tuberculosis Association."

Organized in 1905 as the American Sanatorium Association, the ATS was reorganized in 1939 as the medical section of the NTA and named in honor of Dr. Trudeau, who established the famous sanatorium that bore his name at Saranac Lake, New York. The Society has a membership of more than 5,000 physicians and other scientists in North America and throughout the world. Its official scientific journal is the *American Review of Respiratory Diseases.*

### New Address?

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston 24, West Virginia.

## Study Commission Established By Blue Shield Assn.

A "Blue Shield Study Commission" has been established by the National Association of Blue Shield Plans to undertake a major study of the differences of concept and coverage among the nation's 75 Blue Shield Plans which "have resulted in different approaches to the problem of providing adequate protection to the public."

Dr. Henry S. Blake of Topeka, Kansas, was named chairman of the nine-man commission. Other physicians named were Drs. David B. Allman of Atlantic City, New Jersey, George M. Fister of Ogden, Utah, and Dwight H. Murray of Napa, California.

### Colon Surgery Association Organized

Dr. Warren H. Cole of Chicago, professor and head of the Department of Surgery of the University of Illinois College of Medicine, has been elected president of the newly organized Association for Colon Surgery.

Doctor Cole, an authority in the field of cancer research, also is president of the American Cancer Society and the American Surgical Society.

## Dr. Mildred Mitchell-Bateman Accepts Post in Mental Health Department

Dr. Mildred Mitchell-Bateman, Superintendent of Lakin State Hospital, has accepted appointment as supervisor of the State Department of Mental Health's Division of Professional Services.

The announcement of her appointment was made by Dr. Robert P. Hagerman, State Director of Mental Health, who said that she will act in a consultant capacity and make recommendations with reference to "the professional aspects of the State mental institutions."

Doctor Hagerman said that her activities will include "the encouragement of research, analysis and development of the mental health program, and assistance in recruiting personnel."

Doctor Bateman has been a member of the medical staff of the Lakin institution since 1957, and several months ago was appointed superintendent to succeed Dr. S. O. Johnson, resigned.

Training for the practice of her specialty of psychiatry was had at Winter VA Hospital, Topeka, Kansas. She had postgraduate work at the Menninger School of Psychiatry in that city.

She is a member of the Mason County Medical Society, the West Virginia State Medical Association and the American Medical Association. She is a Diplomate of the American Board of Psychiatry and Neurosurgery.

## Dr. M. B. Williams Reappointed To Advisory Health Board

Dr. Mayes B. Williams, medical director of the Ohio Valley General Hospital in Wheeling, has been reappointed by Governor Cecil H. Underwood as a member of the advisory board to the State Board of Health. The reappointment which was effective July 1, 1960, is for a seven-year term ending July 30, 1967.

**Dr. I. E. Buff of Charleston, right, served as a member of a team which gave physical examinations to physicians attending the annual AMA Meeting in Miami Beach. The other physician in the picture is Dr. Charles E. McArthur of Olympia, Washington. More than 1,300 physicians had physical examinations.**

## Dr. Merle S. Scherr Guest Speaker At Meeting in California

Dr. Merle S. Scherr of Charleston appeared as a guest speaker at a meeting of the Allergy Foundation of North California which was held in San Francisco on June 17. His subject was "Rehabilitation of the Asthmatic Patient."

Doctor Scherr also included in his presentation the showing of the motion picture, "The Hidden Tear," which documents the development of an asthma conditioning program in the Charleston area. The world premiere of the film was held during the 92nd Annual Meeting of the State Medical Association at The Greenbrier in 1959.

## Auxiliary To Maintain Hospitality Booth

A Hospitality Booth, sponsored by the Woman's Auxiliary to the West Virginia State Medical Association, will be open in the Exhibit Hall during the Annual Meeting at The Greenbrier, August 25-27.

All physicians, their wives and guests are cordially invited to stop at the booth often and to make use of its facilities throughout the three-day meeting.

Coffee will be served at the booth from 8:30 until 5 o'clock on Thursday and Friday, and from 8:30 until noon on Saturday, the final day of the meeting.

### Neurology in Great Britain

Medical specialties wax and wane for a variety of reasons. Neurology in the United States, for example, held a high position until the first world war. Then the rise of neurosurgery and the influence of Cushing's powerful personality made many people believe that anything a neurologist could do a neurosurgeon could do better; and neurosurgery added to its prestige by throwing new light upon many functions of the brain. Simultaneously, by a kind of pincer movement psychoanalysis sought to remove much of the mind from the neurologist's province. But now for some time American neurology has been getting its own back, partly by showing that there are many important problems which neither neurosurgery nor psychoanalysis can solve, and partly by doing something towards their solution.

American neurology owes its present thriving state to several factors, the most important of which are the close relationship between neurophysiology, neurochemistry, neuropathology, and clinical neurology, and the expenditure of a great deal of money on training and research. The result is that any senior neurologist who wants to go on doing research can do so, and all promising young neurologists have the opportunity to work on research projects in the departments of senior neurologists who are research-minded.—The Lancet.

It is better to fall on your face than to lean too far backward.—James Thurber.

## National Officers of Auxiliary To Attend Annual Meeting

More than 200 wives of physicians are expected to attend the 36th Annual Meeting of the Woman's Auxiliary to the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 25-27.

Mrs. Robert R. Pittman of Marlinton, the president, will preside during the three-day meeting which will be held in conjunction with the 93rd Annual Meeting of the West Virginia State Medical Association.

Mrs. William Mackersie

Mrs. John M. Chenault

Mrs. William Mackersie of Detroit, Michigan, president of the Woman's Auxiliary to the American Medical Association, will be among the guest speakers and will deliver the keynote address at the opening session on Thursday morning, August 25.

Another prominent guest will be Mrs. John M. Chenault of Decatur, Alabama, president of the Woman's Auxiliary to the Southern Medical Association. She will present an address before the second session on Friday morning, August 26.

### Pre-Convention Meetings

Mrs. Robert R. Pittman, the president, will preside at a pre-convention meeting of the Executive Board which will be held at 9 o'clock on Wednesday evening, August 24, the day preceding the formal opening of the convention.

All Auxiliary members are cordially invited to attend the first session of the Association's House of Delegates which will be held that same evening. Dr. J. C. Huffman of Buckhannon, the president, will present his presidential address at that session.

### Dr. Charles B. Jolliffe Guest Speaker

Physicians, wives and their families are invited to hear an address by Dr. Charles B. Jolliffe at the Association's first general session in the Theatre at 9:00 o'clock on Thursday morning, August 25. Doctor Jolliffe, a native of Mannington, West Virginia, is Vice President and Technical Director of the Radio Corporation of America.

### General Business Sessions

The Auxiliary's general business sessions will be held on Thursday and Friday mornings, leaving the afternoons free for committee meetings and participation in the golf, bridge and other tournaments arranged in connection with the meeting.

Mrs. Pittman will preside at the opening session on Thursday morning, and the invocation and pledge of loyalty will be given by Mrs. J. C. Huffman of Buckhannon, a past president.

The agenda at the first session will include reports of convention committees and recommendations of the Executive Board. Reports of county Auxiliary presidents will also be received, together with reports of the officers and the standing and special committees.

### Address by Mrs. William Mackersie

The guest speaker at the first session will be Mrs. William Mackersie, the AMA Auxiliary president, who will deliver the keynote address. She was installed as president during the annual meeting in Miami Beach in June.

A native of Canada, Mrs. Mackersie has been active in Auxiliary work for more than 25 years. She served as state president for Michigan, 1951-52, and on the national level she has served as chairman of the resolutions committee, 1952-53, chairman of the civil defense committee, 1953-55, member of the Board of Directors, 1955-57, chairman of the revisions committee in 1958, and north central regional vice president, 1958-59. She was named president elect at the Atlantic City meeting in 1959.

Her husband is an anesthesiologist and they have one son and a daughter, both married, and three grandchildren.

Mrs. Mackersie is a registered parliamentarian and is a member of the National Association of Parliamentarians. She also has served as chairman of the welfare department of the Michigan Federation of Woman's Clubs and as a director of the Michigan Health Council.

### Luncheon and Fashion Show

Following adjournment of the first general session on Thursday morning, there will be a luncheon and fashion show for members and guests. Fall fashions will be shown by Alanson's of The Greenbrier and Delray Beach, Florida. Musical selections will be presented by Mr. William Fearnley.

Activities scheduled for Thursday afternoon include a Bridge and Canasta Party in the Trellis Lobby, a naturalist tour and a tour of the Alabama Arts Colony.

### Election of Officers on Friday

The annual Past President's Breakfast will be held at 8 o'clock on Friday morning, with Mrs. G. Thomas Evans of Fairmont, immediate past president, presiding.

Mrs. Pittman will preside at the second general session which will be held at 10 A. M. on Friday. In addition to receiving reports of various committees, new officers will be elected for the coming year following a report of the nominating committee.

Mrs. William Mackersie will install the newly elected officers and the presentation of the president's pin and gavel will be made by Mrs. Pittman. The presentation

of the past president's pin will be made by Mrs. G. Thomas Evans.

### Address by Mrs. Clark K. Sleeth

Mrs. Clark K. Sleeth of Morgantown, who will be installed as president, will deliver her inaugural address following the installation ceremonies.

The new Dean of the West Virginia University School of Nursing, Miss Dorothy Mae Major, will appear as a guest speaker and her subject will be "West Virginia's First University Program in Nursing."

The program that morning will also include an address by Mrs. John M. Chenault, president of the Woman's Auxiliary to the Southern Medical Association. She has been active in Auxiliary work for 15 years and has served as president of her county and state auxiliaries. She also is co-author of the "State Handbook" for Alabama.

A native of Tuscaloosa, Alabama, Mrs. Chenault was graduated from the University of Alabama where she was a member of Phi Beta Kappa. Her husband is a general practitioner in Decatur and they have four children.

### Tennis and Golf Tournaments

The tennis and golf tournaments in connection with the Auxiliary convention will be held on Friday afternoon. Mesdames James P. Baker, Arnold J. Brody and Stuart T. Bray, all of White Sulphur Springs, are in charge of arrangements for the tournaments.

Mrs. Robert R. Pittman
President

There will also be a tour of the Alabama Arts Colony, with demonstrations of rug hooking, weaving and other crafts.

### Dance on Friday Evening

The Woman's Auxiliary is in charge of the entertainment program for the convention. The feature evening entertainment will be a Dance in the Ballroom on Friday evening beginning at 10 o'clock.

A special program will be presented at 10:30 o'clock, after which honor guests will be introduced and golf and tennis prizes awarded.

### Post-Convention Conference

Mrs. Clark K. Sleeth, the incoming president, will preside at a post-convention conference which will be held at 10 A. M. on Saturday, August 27. This meeting will be the final item of business on the formal program.

### Second Session, House of Delegates

Dr. E. Vincent Askey of Los Angeles, California, president of the American Medical Association, will be the principal speaker at the second session of the Association's House of Delegates at 3:30 o'clock on Saturday afternoon. Auxiliary members are cordially invited to attend both sessions of the House of Delegates.

The second session will also feature introductions of West Virginia's "General Practitioner of the Year," and the recipient of the State Medical Association's 1960 four-year scholarship to the WVU School of Medicine. The business session will include the election of officers for the coming year.

### Cocktail Party and Reception

A cocktail party and reception honoring the officers of the West Virginia State Medical Association will be held on the Auditorium Terrace from 6:30 to 7:30 o'clock on Saturday evening. All members of the Auxiliary, the State Medical Association, exhibitors and guests are invited to attend.

### Hospitality Booth

The Auxiliary will sponsor a Hospitality Booth in the Exhibit Hall during the three-day meeting. All physicians, their wives and guests are invited to stop at the booth often and to make use of the facilities throughout the meeting.

Coffee will be served at the booth from 8:30 until 5 o'clock on Thursday and Friday, and from 8:30 until noon on Saturday, the final day of the meeting.

### Convention Committee

Mrs. E. J. Morhous of White Sulphur Springs is convention chairman and Mrs. Harvey A. Martin, also of White Sulphur Springs, co-chairmen. They were appointed by the president, Mrs. Robert R. Pittman.

## Dr. Ward Wylie Heads Delegates To Los Angeles Convention

Dr. Ward Wylie of Mullens was elected chairman of the West Virginia delegates to the Democratic National Convention in Los Angeles and is serving in that capacity at the convention which is being held as this issue of *The Journal* goes to press (July 12).

Doctor Wylie was campaign manager for Senator John F. Kennedy of Massachusetts, candidate for nomination as President, during the primary election campaign in this state last May.

## Dr. Bernard S. Clements Named 'GP of the Year'

Dr. Bernard S. Clements, 78-year-old physician of Matoaka, Mercer County, is West Virginia's "General Practitioner of the Year" for 1960. The selection was made by the Council of the West Virginia State Medical Association from a field of five nominees submitted by component societies. Final action was taken by the Council at the summer meeting in Clarksburg on June 26.

Bernard S. Clements, M. D.

Doctor Clements, who is still active after 53 years of practice, will accept the award during the 93rd annual meeting of the State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

He was born at Manquin, King William County, Virginia, and attended William and Mary College. He received his M. D. degree in 1907 from the Medical College of Virginia and shortly thereafter located for practice at Giatto, Mercer County. Two years later he moved to nearby Matoaka, where he still remains in active practice.

During his first years of practice, Doctor Clements visited his patients on foot, by mule and horseback, and by riding a rail bicycle. In his own words, "I have worn out five railroad wheels, two horses, eight automobiles, walked 10,000 miles and delivered 2,500 babies."

In 1944, he was awarded the Joseph A. Holmes Medal of Honor for performing life-saving emergency surgery inside a coal mine under the most adverse circumstances. Despite his height of six feet, six inches, he successfully amputated the leg of a miner who was caught in a 36-inch seam of coal.

Doctor Clements has always been active in the civic affairs of his community and has held high office in his church as well as in the field of banking. He also has served as president of the Mercer County Medical Society and as a member of the Council of the State Medical Association.

Doctor Clements is the father of three children, one of whom is a physician in New York City.

Doctor Clements' name has been certified to the American Medical Association in Chicago for consideration by its Board of Trustees in connection with the selection by that group of the national "General Practitioner of the Year."

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The youth gets together materials for a bridge to the moon, and at length the middle-aged man decides to make a woodshed with them.—Henry David Thoreau.

## Second Athletic Injury Conference Held at Jackson's Mill

The State Medical Association's Committee on Public Service, for the second consecutive year, cooperated with the West Virginia Secondary Schools Commission in sponsoring an Athletic Injury Conference at a meeting in Jackson's Mill on July 17. The subject was, "Conditioning of the High School Athlete," and addresses were presented by Mr. Ernest Biggs, Head Trainer of Ohio State University, and Dr. William E. Gilmore of Parkersburg.

Dr. Richard W. Corbitt, also of Parkersburg, Chairman of the Public Service Committee, served as moderator of a panel which discussed the matters presented by the two speakers.

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### Relocations

Dr. Frank Greenwald of Rowlesburg has accepted appointment as radiologist at the Veterans Administration Center at Bay Pines, St. Petersburg, Florida, effective July 1. Doctor Greenwald was formerly radiologist to the Garrett County Memorial Hospital, Oakland, Maryland, Grafton City Hospital, Grant County Memorial Hospital, and Hampshire Memorial Hospital. He was also consultant in radiology to the VA Hospital in Clarksburg.

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Dr. Don F. Shreve of White Sulphur Springs has moved to Wharton, where he will continue in general practice.

* * * *

Dr. Daniel B. Gordon of Elkins has moved to Wheeling where he is now associated with Dr. N. L. Haislip and Dr. A. J. Barger in the practice of his specialty of radiology. He is now a member of the staff of the Wheeling Hospital and the Reynolds Memorial Hospital in Glen Dale, and a consultant in radiology to the Wetzel County Hospital in New Martinsville.

* * * *

Dr. George E. Farrell of Webster Springs has moved to Lewisburg, where he has offices at 117 East Washington Street. He will continue the practice of his specialty of radiology in several hospitals adjacent to the area in which he now resides.

* * * *

Dr. John M. Grubb of Charleston has accepted a residency in obstetrics and gynecology at Memorial Hospital in Charleston, effective July 1, 1960. Dr. J. L. Mangus of Charleston, who has just completed an internship at Memorial Hospital, has taken over Doctor Grubb's practice and will occupy his offices at 309 41st Street, S. E., in Charleston.

* * * *

Dr. James E. Boggs, who has just completed a three-year residency in surgery at Memorial Hospital in Charleston, is now associated with Dr. Theodore P. Mantz in the practice of his specialty of general surgery and oncology, with offices at 601 Atlas Building, Charleston. Before beginning his residency in 1957, he had engaged in general practice at Williamson.

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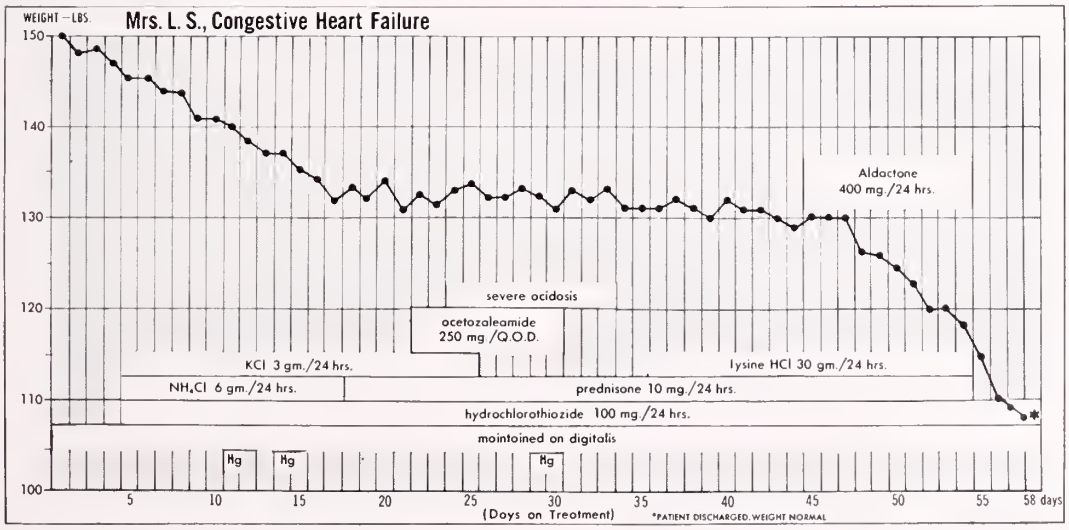

# CONVENTION PROGRAM

## *93rd Annual Meeting*

of the

## *West Virginia State Medical Association*

**THE GREENBRIER, WHITE SULPHUR SPRINGS**

**August 25-27, 1960**

### WEDNESDAY AFTERNOON

**August 24**

**(Eastern Standard Time)**

2:30-4:30—Registration, Main Floor Lobby.

2:30—Medical Scholarships Committee. Carl B. Hall, M. D., *presiding.* (Pierce Room).

2:30—Mental Health Committee. L. J. Pace, M. D., *presiding.* (Jackson Room).

2:30—Rural Health Committee. Earl L. Fisher, M. D., *presiding.* (Arthur Room).

3:00—Committee on Medical Economics. James S. Klumpp, M. D., *presiding.* (Buchanan Room).

3:00—Cancer Committee. Hu C. Myers, M. D., *presiding.* (Tyler Room).

4:00—Pre-Convention Meeting of the Council. George F. Evans, M. D., *presiding.* (Lee Room, Virginia Wing).

### WEDNESDAY EVENING

8:30-9:30—Registration.

9:00—First Session of the House of Delegates. J. C. Huffman, M. D., *presiding.* (Fillmore and Van Buren Rooms).

Presidential Address—J. C. Huffman, M. D., President, West Virginia State Medical Association.

Business Meeting.

### THURSDAY MORNING

**August 25**

8:30—Motion Picture. Jules F. Langlet, M. D., in charge. (Theatre). "Machine Mimics Man."—A film describing the operation of the artificial kidney.

8:30-5:00—Registration, Main Floor Lobby.

***Opening Exercises—Theatre***

9:00—Call to Order—Seigle W. Parks, M. D., Chairman, Program Committee.

Invocation—Walter E. Vest, M. D., Huntington.

Address of Welcome—J. C. Huffman, M. D., President, West Virginia State Medical Association.

Address by Charles B. Jolliffe, Ph. D., Vice President and Technical Director of the Radio Corporation of America. Subject: "Electronics and Medicine."

10:00—Recess for Visiting Exhibits.

***First General Session***

**Symposium on Pyelonephritis**

*Moderator*: Kenneth G. MacDonald, M. D.

10:30—Panelists:

Thomas A. Stamey, M. D., Associate Professor of Urology, The Johns Hopkins University Medical School, Baltimore, Maryland.

John B. Hazard, M. D., Chairman of the Division of Pathology and Head of the Department, Cleveland Clinic Foundation, Cleveland, Ohio.

George A. Wolf, Jr., M. D., Dean and Professor of Clinical Medicine, University of Vermont College of Medicine, Burlington, Vermont.

12:30—Recess for Lunch and Visiting Exhibits.

### THURSDAY AFTERNOON

**August 25**

2:00—Resolutions Committee. Albert C. Esposito, M. D., *presiding.* (Washington Room).

2:00—Open Meeting, West Virginia State Society of Allergy. (Fillmore Room).

Address of Welcome by the president of the Society, Sarah L. C. Stevens, M. D.

Scientific program with Merle S. Scherr, M. D., as *Moderator.*

Guest Speakers: Ethan Allan Brown, M. D., Boston. Subject: "Single Annual Injection Treatment of Pollinosis."

M. Murray Peshkin, M. D., New York City. Subject: "Respiratory Allergy with Negative Cutaneous Tests to Inhalant Allergens: Diagnosis and Treatment."

Panel Discussion, with audience participation; demonstration of repository therapy or "Single Annual Injection Treatment of Allergic Diseases."

5:30—Annual Meeting, West Virginia Chapter, Medical College of Virginia Alumni Association. Charles M. Scott, M. D., in charge. Cocktails to follow. (West Virginia Room).

Guests: Richard A. Michaux, M. D., President, MCV Alumni Association; William F. Maloney, M. D., Dean, School of Medicine; and Mr. R. Reginald Rooke, Immediate Past President of the Alumni Association and President of the National Association of Retail Druggists.

## THURSDAY EVENING

10:00—Dancing in the Ballroom.

## FRIDAY MORNING
### August 26

8:30—Motion Picture. Jules F. Langlet, M. D., in charge. (Theatre). "Removal and Shipment of Eyes for Corneal Transplant." The film will be preceded by a brief discussion by Dr. Ralph W. Ryan of Morgantown.

8:30-5:00—Registration. Main Floor Lobby.

### *Program by WVU School of Medicine*

*Moderator*: William A. Thornhill, Jr., M. D.

9:15—"Your University."—President Elvis J. Stahr, Jr. "A Medical Center for the 60's."—Kenneth E. Penrod, Ph. D., Vice President—Medical Affairs.

10:00—Recess for Visiting Exhibits.

10:30—"Surgical Aspects of Hyperadrenalism."—Bernard Zimmermann, M. D., Professor and Chairman of the Department of Surgery.

"Medical Aspects of Hyperadrenalism."—Edmund B. Flink, M. D., Professor and Chairman of the Department of Medicine.

"Cardiac Aneurysms: Diagnosis and Surgical Treatment."—Herbert E. Warden, M. D., Associate Professor of Surgery.

12:30—Recess for Lunch and Visiting Exhibits.

## FRIDAY AFTERNOON
### August 26

2:00—Section on Orthopedic Surgery. Maxwell H. Bloomberg, M. D., *presiding*. (West Virginia Room).

Guest Speaker: Joseph H. Kite, M. D., Atlanta, Georgia. Subject: "Congenital Metatarsus Varus Deformity."

2:00—Section on Urology. Paul L. McCuskey, M. D., *presiding*. (Buchanan Room).

Guest Speaker: Thomas A. Stamey, M. D., Baltimore, Maryland. Subject: "The Diagnosis of Curable Unilateral Renal Hypertension by Ureteral Catheterization."

Business Meeting.

2:00—Section on Internal Medicine. E. L. Crumpacker, M. D., *presiding*. (Fillmore Room).

Guest Speakers: Edmund B. Flink, M. D., Morgantown. Subject: "Metabolic Bone Diseases."

George A. Wolf, Jr., M. D., Burlington, Vermont. Subject: "Use of Anticoagulants in Cerebral Vascular Disease."

2:30—Section on Neurology, Neurosurgery and Psychiatry. Albert L. Wanner, M. D., *presiding*. (Jackson Room).

Business Meeting.

2:30—West Virginia Academy of Ophthalmology and Otolaryngology. Nime K. Joseph, M. D., *presiding*. (Pierce Room).

Scientific Program, followed by Business Meeting.

3:00—West Virginia Diabetes Association. Marion F. Jarrett, M. D., *presiding*. (Fillmore Room).

Business Meeting.

3:30—West Virginia Society of Internal Medicine. Pat A. Tuckwiller, M. D., *presiding*. (Fillmore Room).

Business Meeting.

## FRIDAY EVENING

10:00—Auxiliary Entertainment and Dance. (Ballroom).

## SATURDAY MORNING
### August 27

8:30—Motion Picture. Jules F. Langlet, M. D., in charge. (Theatre). "Improved Method of Repair of Imperforate Anus with Rectovaginal Fistula."—Willis J. Potts, M. D.

8:30-2:00—Registration. Main Floor Lobby.

### *Third General Session—Theatre*

*Moderator*: G. Thomas Evans, M. D.

9:30—"Pediatric Gynecology."—Roger B. Scott, M. D., Associate Professor of Obstetrics and Gynecology, Western Reserve University School of Medicine, Cleveland, Ohio.

10:15—"Anesthesia in the Complications of Pregnancy." —Vincent J. Collins, M. D., Associate Professor of Anesthesiology, New York University Medical Center, New York City.

11:00—Recess for Visiting Exhibits.

11:30—"Problems of Adolescence."—Edward M. Litin, M. D., Consultant, Section of Psychiatry, Mayo Clinic, Rochester, Minnesota.

12:15—Recess for Lunch and Visiting Exhibits.

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10:30—West Virginia Association of Pathologists. David F. Bell Jr., M. D., *presiding.* (Buchanan Room).

Business Meeting.

## SATURDAY AFTERNOON

2:00—Section on Orthopedic Surgery. Maxwell H. Bloomberg, M. D., *presiding.* (West Virginia Room).

Guest Speaker: Joseph H. Kite, M. D., Atlanta. Subject: "Torsional Deformities of the Lower Extremities."

2:00—West Virginia Obstetrical and Gynecological Society. Gates J. Wayburn, M. D., *presiding.* (Jackson Room).

Guest Speaker: Roger B. Scott, M. D., Cleveland, Ohio. Subject: "The Correlation Between Psychology and Diagnostic Cervical Biopsy."

Business Meeting.

2:00—West Virginia Pediatric Society. W. W. Currence, M. D., *presiding.* (Tyler Room).

Guest Speakers: Edward M. Litin, M. D., Rochester, Minnesota. Subject: "Effects of Physical Handicaps on Personality Development in Children."

Roger B. Scott, M. D., Cleveland, Ohio. Subject: "Pediatric and Adolescent Gynecology."

Discussion, with audience participation, after the presentation of each paper.

Business Meeting and Election of Officers.

2:15—Section on Surgery. Charles E. Staats, M. D., *presiding.* (Van Buren Room).

Speakers: Bernard Zimmermann, M. D., and Herbert E. Warden, M. D., Department of Surgery, WVU School of Medicine, Morgangantown.

2:30—West Virginia Society of Anesthesiologists. Logan W. Hovis, M. D., *presiding.* (Buchanan Room).

Guest Speaker: Vincent J. Collins, M. D., New York City. Subject: "Evaluation of Patients for Anesthesia."

3:30—Second and Final Session of the House of Delegates. J. C. Huffman, M. D., *presiding.* (Theatre).

Address: E. Vincent Askey, M. D., President, American Medical Association.

Introduction of West Virginia's "General Practitioner of the Year."

Introduction of President of Woman's Auxiliary and honor guests.

Introduction of recipient of 1960 Medical Scholarships Award.

Business Meeting.

Election of Officers.

Installation of John W. Hash, M. D., of Charleston as President of the State Medical Association.

## SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception honoring the officers of the West Virginia State Medical Association. (Chesapeake Hall Terrace).

10:00—Dancing in the Ballroom.

# CONVENTION SPEAKERS

**(Biographical Sketches)**

E. Vincent Askey, M. D., of Los Angeles, California, President of the American Medical Association, was born in Sligo, Pennsylvania. He received his M. D. degree from the University of Pennsylvania School of Medicine in 1921 and served an internship and residency at the Hospital of the Protestant Episcopal Church and Kensington Hospital for Women in Philadelphia, 1921-23. He then moved to Los Angeles and since that time has served as a member of the Surgical Staff at St. Vincent's Hospital in that city.

E. Vincent Askey, M. D.

Doctor Askey, who was installed as President of the American Medical Association during the Annual Meeting at Miami Beach in June, served for several years as Vice Speaker and Speaker of the American Medical Association's House of Delegates.

He also served as President of the Los Angeles County Medical Association and the California State Medical Association.

He is certified by the American Board of Surgery and is a Fellow of the American College of Surgeons. In 1958, he was awarded an honorary degree of Doctor of Science by Allegheny College in Pennsylvania.

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Ethan Allan Brown, M. D., of Boston, Massachusetts, Editor of *Annals of Allergy*, was born in London, England. He received his medical training in that country and served as Demonstrator in Biology and Assistant Lecturer, St. Mary's Hospital Medical School, University of London, 1932-35. He served as a Fellow in Medicine at the Lahey Clinic in Boston, 1935-36, and as a staff member of the Department of Internal Medicine (Allergy Section), 1936-38.

Ethan Allan Brown, M. D.

He was appointed Lecturer in Medicine (Allergy) at Tufts University School of Medicine in Boston, 1939-46; Instructor in Medicine, 1946-47; Assistant Professor of Pediatrics, 1951-58; and Consultant in Allergy, Department of Clinical Laboratories, 1953-58.

Doctor Brown is a past president of the American College of Allergists and has served as editor of several medical journals. He has served since 1942 as Impartial Examining Physician for the Commonwealth of Massachusetts and is secretary of the Committee on Allergy of the American College of Chest Physicians. He is a member of the Royal College of Surgeons and a Licentiate of the Royal College of Physicians. He is also a member of the Massachusetts Medical Society, American Medical Association and the Mississippi Valley Medical Society.

In 1958, Doctor Brown was awarded first prize in the Mississippi Valley Medical Society essay contest.

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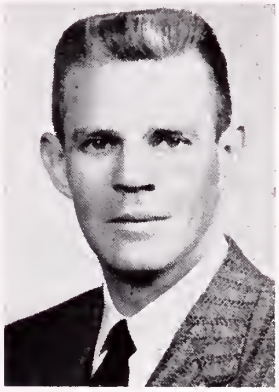
Vincent J. Collins, M. D., of New York City, Associate Professor of Anesthesiology, New York University Medical Center, was born in Haverstraw, New York.



Vincent J. Collins, M. D.

He received his M. D. degree from the Yale University School of Medicine in 1942, and served his internship at Albany Hospital in Albany, New York, 1942-43. He served residencies at that hospital and at Bellevue Hospital.

During World War II, he served with the Medical Corps, AUS, and was released in 1946 with the rank of Major.

He served as Associate Anesthesiologist at Doctors Hospital in New York City, 1947-49, and as Director of the Department of Anesthesiology at St. Vincent's Hospital, 1949-58. In 1957, he was appointed Associate Professor of Anesthesiology at New York University Medical Center.

He is a Fellow of the American College of Anesthesiology and is a member of the Medical Society of the State of New York and the American Medical Association. He has also served as secretary and president of the New York State Society of Anesthesiologists.

Doctor Collins is Secretary of the Section on Anesthesiology of the American Medical Association and is an advisor on inhalation therapy to the AMA Council on Medical Education.

Edmund B. Flink, M. D., of Morgantown, West Virginia, Professor and Chairman of the Department of Medicine, West Virginia University School of Medicine, was born in Isanti, Minnesota. He received his M. D. degree from the University of Minnesota Medical School in 1938 and served his internship at the University of Minnesota Hospitals, 1937-39. He also served a residency at that hospital, 1939-42.

Edmund B. Flink, M. D.

He was appointed Instructor in Medicine at the University of Minnesota Medical School in 1942; Assistant Professor, 1943; Associate Professor, 1950; and Professor, 1957. He served as Visiting Professor at Seoul National University in Korea, 1957-58. He was named to his present position at the WVU School of Medicine in May of this year.

He is a Fellow of the American College of Physicians and is a member of the Hennepin County Medical Society, Minnesota Medical Society, and the American Medical Association.

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John B. Hazard, M. D., Chairman of the Division of Pathology and Head of the Department, Cleveland Clinic Foundation, Cleveland, Ohio, was born in Pennsylvania. He received his M. D. degree from Harvard Medical School in 1930, and served a residency at the Boston City Hospital in that city, 1930-31.

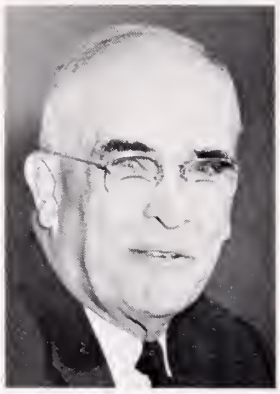
John B. Hazard, M. D.

He served as Assistant in Pathology at the Boston City Hospital, 1931-34, and as Pathologist to the Faulkner Hospital, 1934-46. He served as Assistant Professor of Pathology and Bacteriology at Tufts University School of Medicine, 1941-46, and as Consulting Pathologist at the Robert B. Brigham Hospital in Boston, 1938-46.

He served overseas with the Medical Corps, AUS, during World War II and was released with the rank of Lieutenant Colonel.

Doctor Hazard has served as Head of the Pathology Department at the Cleveland Clinic Foundation since 1946, and he is also Associate Professor of Pathology at Western Reserve University School of Medicine. He is a Diplomate of the American Board of Pathology.

Charles B. Jolliffe, Ph. D., Vice President and Technical Director of the Radio Corporation of America, was born in Mannington, West Virginia. He was graduated from West Virginia University in 1915 and received a Masters Degree from the same school in 1920. He received a Ph. D. from Cornell University in 1922.



Charles B. Jolliffe, Ph.D.

In 1942, he was awarded an honorary LL. D. degree by West Virginia University.

From 1916 to 1922, except for a period of service in World War I, he taught physics at Ohio State University, West Virginia University and Cornell University. In 1922, he accepted a position with the Radio Section of the Bureau of Standards and served there for eight years. In 1930, Doctor Jolliffe was appointed Chief Engineer of the Federal Communications Division. He resigned in 1935 to become associated with RCA.

During World War II, he served as Chairman of the Communications Division of the National Defense Research Committee, Office of Scientific Research and Development. He also was Secretary of the Industry Advisory Committee, Board of War Communications, and a member of the Engineers Defense Board. For his wartime contributions to the OSRD, he received Army and Navy Certificates of Appreciation.

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J. H. Kite, M. D., of Atlanta, Georgia, Associate Professor of Clinical Orthopedic Surgery, Emory University School of Medicine, was born in Elkton, Virginia. He received his M. D. degree from the Johns Hopkins University Medical School in 1918 and served an internship at Johns Hopkins Hospital. He served residencies at that hospital and at University Hospital and Grady Hospital, both in Georgia.

J. H. Kite, M. D.

In addition to his duties at Emory, he is Surgeon-in-Chief at the Scottish Rite Hospital for Crippled Children in Decatur, Georgia. He is certified by the American Board of Orthopedic Surgery and is a member of the American College of Surgeons, American Academy of Orthopedic Surgeons, International Society of Orthopedics and Traumatology and the American Orthopedic Association.

Edward M. Litin, M. D., of Rochester, Minnesota, Consultant, Section of Psychiatry, Mayo Clinic, was born in Minneapolis, Minnesota. He received his M. D. degree from the University of Minnesota Medical School in 1945 and served his internship at the University of Utah in Salt Lake City, 1945-46. He then served for three years as a Captain in the Medical Corps of the United States Army.

Edward M. Litin, M. D.

Since 1948, he has served as a Consultant in the Section of Psychiatry of the Mayo Clinic.

Doctor Litin is a Diplomate of the American Board of Psychiatry and Neurology and is a member of the Minnesota State Medical Association and the American Medical Association.

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Kenneth E. Penrod, Ph. D., of Morgantown, West Virginia, Vice President-Medical Affairs, West Virginia University, was born in Blanchester, Ohio. He was graduated from Miami (Ohio) University and he received his Ph. D. degree from Iowa State College in 1942.

Kenneth E. Penrod, Ph.D.

Prior to World War II, Doctor Penrod was a member of the faculty at Miami University. He served for four years during the war as an aviation physiologist, initially at Wright Field, Dayton, Ohio, and later with the Central Medical Establishment of the 8th Air Force in England.

Following the war, he joined the faculty at the Boston University School of Medicine. In 1950, he was appointed Associate Professor of Physiology at Duke University School of Medicine. He was named Assistant Dean in 1952 and was promoted to the rank of Professor of Physiology in 1957. He assumed his duties at West Virginia University on July 1, 1959.

Doctor Penrod's duties include the internal coordination of all the Medical Center programs, including those of the Schools of Medicine, Dentistry, Pharmacy, Nursing and the Teaching Hospital.

Doctor Penrod is a member of Phi Beta Kappa and the American Association for the Advancement of Science. Also, he is a member of the editorial boards of the *Journal of Medical Education* and the *Journal of Experimental Medicine.*

M. Murray Peshkin, M. D., of New York City, Clinical Professor of Medicine and Pediatrics (Allergy), Albert Einstein College of Medicine, Yeshiva University, received his M. D. degree from Fordham University School of Medicine in 1914.

M. Murray Peshkin, M. D.

Doctor Peshkin also serves as Consultant Allergist, Mt. Sinai Hospital, New York City, and as Chief Medical Consultant, Jewish National Home for Asthmatic Children, Denver, Colorado.

He is certified by the American Board of Internal Medicine and is a member of the Medical Society of the State of New York and the American Medical Association.

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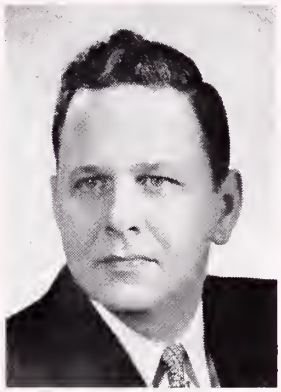
Roger B. Scott, M. D., of Cleveland, Ohio, Associate Professor of Obstetrics and Gynecology, Western Reserve University School of Medicine, was born in Moundsville, West Virginia. He was graduated from West Virginia University in 1934 and from the two-year School of Medicine in 1936. He received his M. D. degree from the Johns Hopkins University School of Medicine in 1938 and served an internship and residency at the Johns Hopkins Hospital, 1939-44.



Roger B. Scott, M. D.

During World War II, he served for two years with the Medical Corps of the United States Navy.

In 1946, he was named Instructor in Gynecology at the Johns Hopkins University School of Medicine, and was also a member of the gynecological staff at the Johns Hopkins Hospital and Church Home Hospital.

Doctor Scott was named Associate Professor of Obstetrics and Gynecology at Western Reserve University School of Medicine in 1950 and he also has served as Gynecologist in Charge at University Hospitals of Cleveland. He has served several years as an Associate Examiner of the American Board of Obstetrics and Gynecology.

He is a Diplomate of the American Board of Obstetrics and Gynecology and is a member of Phi Beta Kappa, the Academy of Medicine of Cleveland and the American Medical Association. He is also a member of the Continental Gynecological Society and American Association of Obstetrics and Gynecology.

Elvis J. Stahr, Jr., of Morgantown, West Virginia, President of West Virginia University, was born in Hickman, Kentucky. He was graduated from the University of Kentucky in 1936 with the highest grades in the history of that institution.

Elvis J. Stahr, Jr.

He won a Rhodes Scholarship and spent three years at Oxford University where he was awarded three additional degrees (B. A. in Jurisprudence, Bachelor of Civil Law, and M. A.). He later was awarded a degree in Chinese language at Yale University.

He practiced law in New York City for eight years and then entered the United States Army at the outbreak of World War II. He served overseas for more than two years and received seven medals and several battle stars. He was discharged with the rank of Lieutenant Colonel.

In 1947, President Stahr was appointed Associate Professor of Law at the University of Kentucky, and in 1948, at the age of 32, was promoted to Professor and made Dean of the College of Law. During the Korean War, he took leave from the University to serve as special assistant to the Secretary of the Army. In 1954, he was made provost of the University of Kentucky.

In 1957, he accepted appointment as vice chancellor at the University of Pittsburgh where he was in charge of numerous schools within that institution.

His appointment at West Virginia University was announced by the Board of Governors on August 2, 1958.

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Thomas A. Stamey, M. D. of Baltimore, Maryland, Associate Professor of Urology, The Johns Hopkins University Medical School. He received his M. D. degree from the Johns Hopkins University Medical School in 1952, and served a residency at the Brady Urological Institute, 1952-56.

Thomas A. Stamey, M. D.

He served in the Medical Corps of the United States Air Force, and was Chief Urological Consultant to the Armed Forces in the United Kingdom, 1956-58.

Doctor Stamey returned to the Johns Hopkins University Medical School in 1958 as Assistant Professor of Urology, and was named Associate Professor of Urology, July 1, 1960. He has also served as Chief of Urology at the Baltimore City Hospital since 1958.

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Herbert E. Warden, M. D., of Morgantown, West Virginia, Associate Professor of Surgery, West Virginia University School of Medicine, was born in Cleveland, Ohio. He received his M. D. degree from the University of Chicago School of Medicine in 1946, and served his internship at the University of Chicago Clinics. He then served for two years with the Medical Corps of the United States Navy.

Herbert E. Warden, M. D.

In 1951, he joined the staff of the University of Minnesota Hospitals as an Assistant Resident in Surgery. At the time of his appointment to the staff at the WVU School of Medicine, he was serving as Instructor in Surgery and Staff Surgeon at the University of Minnesota Hospitals. He was awarded a Ph. D. degree by the University of Minnesota at the conclusion of his postgraduate work there.

Doctor Warden received the Albert Lasker Award for Medical Research from the American Public Health Association in 1955. He also received AMA Certificates of Merit for scientific exhibits on open heart surgery in 1955 and 1957. He was the recipient of the Hekteon Gold Medal in 1957.

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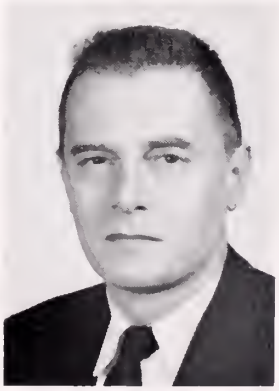
George A. Wolf, Jr., M. D., Dean and Professor of Clinical Medicine, University of Vermont College of Medicine, was born in East Orange, New Jersey.

He received his M. D. degree from Cornell University Medical College in 1941, and served his internship at New York Hospital, 1941-42. He served a residency at the same hospital, 1942-44.

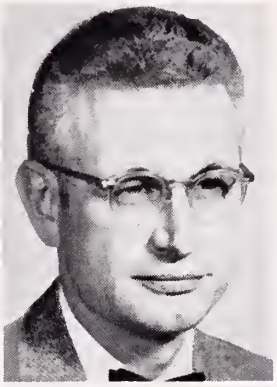


George A. Wolf, Jr., M. D.

In 1943, he was appointed Instructor in Medicine at Cornell University Medical College and in 1949 was named Assistant Professor of Clinical Medicine. He was appointed Dean and Professor of Clinical Medicine at the University of Vermont College of Medicine in 1952.

He is a Fellow of the American College of Physicians and is a member of Phi Beta Kappa, the Vermont State Medical Society and the American Medical Association.

Bernard Zimmermann, M. D., of Morgantown, West Virginia, Professor and Head of the Department of Surgery, West Virginia University School of Medicine, was born in St. Paul, Minnesota. He received his M. D. degree from Harvard Medical School in 1945, and remained there three additional years conducting research in the Department of Pharmacology. He served an internship at Boston City Hospital, 1945-46.



**Bernard Zimmermann, M. D.**

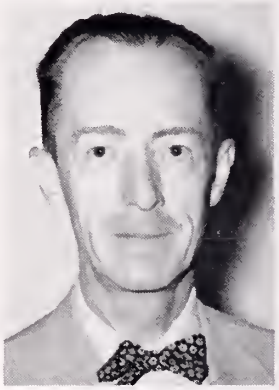
Doctor Zimmermann served as Medical Fellow, Department of Surgery, University of Minnesota Medical School, 1951-53. He was appointed Instructor in the Department of Surgery at the Minnesota Medical School in 1953; Assistant Professor, 1953; Associate Professor, 1956; and Professor, 1959. During that time he also served as Coordinator of the Cancer Training Program. He was named to his present position at the WVU School of Medicine in March of this year.

He is certified by the American Board of Surgery and the Board of Thoracic Surgery, and is a member of the Minnesota State Medical Association and the American Medical Association.

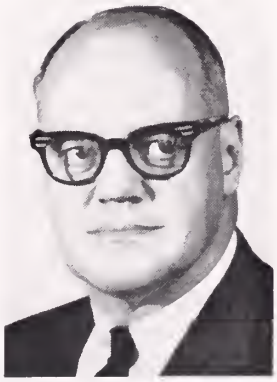
# 1960
# Program Committee

Seigle W. Parks, M. D.
Chairman

Theresa O. Snaith, M. D.
Weston



W. A. Thornhill, Jr., M. D.
Charleston



G. Thomas Evans, M. D.
Fairmont

Kenneth G. MacDonald, M. D.
Charleston

# DELEGATES AND ALTERNATES

**B-R-T** (3)—Delegates, Guy H. Michael, Jr., Parsons; A. Kyle Bush, Philippi; and Charles L. Leonard, Elkins. Alternates, A. C. Thompson, Elkins; Samuel C. Johnson, Parsons; and Ernest Guy, Philippi.

**BOONE** (2)—Delegates, H. H. Howell, Madison.

**BROOKE** (2)—Delegates, J. P. McMullen, Wellsburg; and Ralph McGraw, Follansbee. Alternate, James E. Wise, Follansbee.

**CABELL** (8)—Delegates, A. C. Esposito, John F. Morris, R. J. Stevens, Jack Leckie, Ray M. Bobbitt, W. E. Bray, Jr., G. J. Eder and Walter C. Swann, Huntington. Alternates, John E. Stone, Oscar B. Biern, H. R. Crews, Sarah L. C. Stevens, George M. Lyon, J. M. Carter, Walter E. Vest and Roy A. Edwards, Jr., Huntington.

**CENTRAL WEST VIRGINIA** (4)—Delegates, I. F. Hartman, Buckhannon; Theresa O. Snaith, Weston; Edward H. Hunter, Richwood; and Jane Freeman, Buckhannon. Alternates, W. W. Huffman, Gassaway; C. R. Davisson and Elden H. Pertz, Weston; and George B. Edmiston, Webster Springs.

**EASTERN PANHANDLE** (3)—Delegates, F. A. Hamilton, Jr., Martinsburg; Halvard Wanger, Shepherdstown; and Jules F. Langlet, Charles Town. Alternates, C. Vincent Townsend, N. B. Groves and E. Andrew Zepp, Martinsburg.

**FAYETTE** (3)—Delegates, W. P. Bittinger, Summerlee; and Joe N. Jarrett and B. F. Puckett, Oak Hill. Alternate, T. Kerr Laird, Montgomery.

**GREENBRIER VALLEY** (3)—Delegates, Harvey A. Martin, White Sulphur Springs; John M. Foley, Frankford; and James W. Hamilton, Marlinton. Alternate, Robert R. Pittman, Marlinton.

**HANCOCK** (3)—Delegates, Ray S. Greco, Richard E. Flood and Myer Bogarad, Weirton. Alternates, Emil Capito and James L. Thompson, Weirton.

**HARRISON** (4)—Delegates A. J. Weaver, M. E. Farrell, A. R. Marks and J. A. Thompson, Clarksburg. Alternates, R. T. Humphries, D. H. Lough, and J. K. Pickens, Clarksburg; and D. M. Robinson, Bridgeport.

**KANAWHA** (13)—Delegates, Milton J. Lilly, James W. Lane, R. R. Summers, A. B. Curry Ellison, Robert C. Bock, Howard A. Swart, H. M. Hills, Jr., P. A. Tuckwiller, Kenneth G. MacDonald, Carl B. Hall, R. T. Linger and D. Franklin Milam, Charleston; and Edward Jackson, St. Albans. Alternates, C. M. Caudill, George R. Callender, Jr., William B. Rossman, Jerill D. Cavender, and John T. Chambers, Charleston; William D. Crigger, South Charleston; and D. E. Cunningham, St. Albans.

**LOGAN** (3)—Delegates, Luke Combs, Man; and Everett H. Starcher and James L. Patterson, Logan. Alternates, Thomas P. Long, Lorado; Frank R. Jamison, Logan; and Henry K. Bobroff, Man.

**MARION** (4)—Delegates, F. W. Mallamo, C. S. Lawson, Jr., and G. T. Evans, Fairmont; and S. L. Stillings, Mannington. Alternates, W. T. Lawson and J. C. Morgan, Fairmont; and R. R. Frye, Mannington.

**MARSHALL** (2)—Delegates, Andrew J. Barger, Glendale; and J. W. Myers, Moundsville. Alternates, W. Paul Bradford and H. B. Ashworth, Moundsville.

**MASON** (2)—Delegates, Don F. Hatten and William H. Roush, Pt. Pleasant. Alternates, Lewis D. Telle, Pt. Pleasant; and Mildred Mitchell-Bateman, Lakin.

**McDOWELL** (3)—Delegates, A. J. Villani and R. H. Edwards, Welch; and J. H. Burke, Pageton. Alternates, F. L. Johnston, D. Castrodale and G. L. Fischer, Welch.

**MERCER** (4)—Delegates, W. H. St. Clair, Jr., Upshur Higginbotham and John J. Mahood, Bluefield; and L. J. Pace, Princeton. Alternates, R. O. Rogers, Jr., and Charles M. Scott, Bluefield; and J. I. Markell and Gordon L. Todd, Jr., Princeton.

**MINGO** (2)—Delegates, W. W. Scott and Joseph E. Johnson, Williamson. Alternates, Russell A. Salton and Frank J. Burian, Williamson.

**MONONGALIA** (4)—Delegates, C. A. Logue, Maynard P. Pride, Eldon B. Tucker and John J. Lawless, Morgantown. Alternates, Clark K. Sleeth, George A. Curry, French R. Miller and David Z. Morgan, Morgantown.

**OHIO** (6)—Delegates, R. J. Reed, Jr., C. B. Buffington, George M. Kellas, A. K. Butler, N. K. Joseph and L. A. Lyon, Wheeling. Alternates, M. B. Williams, Howard G. Weiler, Wilda S. Joseph, Robert T. Bandi, W. E. McNamara and H. G. Dickey, Jr., Wheeling.

**PARKERSBURG ACADEMY** (5)—Delegates, Robert M. Biddle, Richard W. Corbitt, and Harold W. Ulch, Parkersburg; Jack J. Stark, Belpre, Ohio; and Martha J. Coyner, Harrisville. Alternates, Randall Connolly, Vienna; O. H. Brundage, S. William Goff and Robert D. Crooks, Parkersburg; and Asel P. Hatfield, Harrisville.

**POTOMAC VALLEY** (3)—Delegates, V. L. Dyer and M. F. Townsend, Petersburg; and P. R. Wilson, Piedmont. Alternates, Charles J. Sites, Franklin; and J. H. Wolverton, Jr., Piedmont.

**PRESTON** (2)—Delegates, W. P. Johnson, Jr., Masontown; and W. R. Wolverton, Kingwood. Alternates, A. L. Starkey, Hopemont; and Alfred Owre, Jr., Aurora.

**RALEIGH** (5)—Delegates, Clyde A. Smith, Preston C. Davis, J. W. Whitlock, G. C. Hedrick, Jr., and Clark Kessel, Beckley. Alternates, W. W. McKinney, Doff D. Daniel, Ross P. Daniel and T. S. Wilder, Beckley.

**SUMMERS** (2)—Delegates, J. W. Stokes and A. W. Holmes, Hinton. Alternates, Jack D. Woodrum and B. W. McNeer, Hinton.

**TAYLOR** (2)—Delegates, Herbert N. Shanes and Paul P. Warden, Grafton. Alternates, Charles A. Haislip and R. D. Stout, Grafton

**WETZEL** (2)—Delegates, Charles P. Watson and Lemoyne Coffield, New Martinsville. Alternates, John O. Theiss and Kent M. Hornbrook, New Martinsville.

**WYOMING** (2)—Delegates, Ross E. Newman and B. W. Steele, Mullens. Alternates, E. M. Wilkinson, Pineville; and R. C. Hatfield, Oceana.

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# Reception Committee

C. R. Davisson, *Chairman*

Robert R. Frye
J. D. H. Wilson
Kenneth G. MacDonald
Charles A. Hoffman
Paul L. McCuskey

David F. Bell, Jr.
Herman Fischer
J. Evan Sadler
Richard V. Lynch, Jr.
P. A. Tuckwiller

Robert U. Drinkard
George F. Evans
David Z. Morgan
Edward J. Van Liere
Justus C. Pickett

Maynard P. Pride
Henry M. Hills, Jr.
E. Lyle Gage
I. Ewen Taylor
Clark K. Sleeth

A. B. Curry Ellison
G. Thomas Evans
Gates J. Wayburn
A. J. Villani
D. E. Greeneltch
Logan W. Hovis

Newman H. Newhouse
Theresa O. Snaith
W. W. Currence
A. R. Marks
Grover C. Hedrick, Jr.
Walter E. Vest

Frank J. Holroyd
Charles A. Hoffman
J. Keith Pickens
A. L. Wanner
J. E. Echols
Charles T. Lively
Hu C. Myers
James S. Klumpp

## Official Program
## WOMAN'S AUXILIARY
### to the
### West Virginia State Medical Association
### 36th Annual Meeting

**The Greenbrier**
**White Sulphur Springs**
**August 25-27, 1960**

### WEDNESDAY EVENING
### August 24

9:00—Pre-Convention Meeting of Executive Board. Mrs. Robert R. Pittman, President, *presiding* (Pierce Room).

9:00—First Session, House of Delegates (Fillmore and Van Buren Rooms).

Annual Address of the President, J. C. Huffman, M. D., Buckhannon, W. Va. All Auxiliary members are invited and urged to attend both sessions of the House of Delegates.

10:00-12:00—Dancing in the Ballroom.

### THURSDAY MORNING
### August 25

9:00—Address by Charles B. Jolliffe, Ph.D., Vice President and Technical Director, Radio Corporation of America, at formal opening of 93rd Annual Meeting of West Virginia State Medical Association. All Auxiliary members are invited and urged to attend (Theatre).

10:00—Formal Opening of Convention. Mrs. Robert R. Pittman, President, *presiding* (Fillmore and Van Buren Rooms).

Invocation and Pledge of Loyalty, Mrs. J. C. Huffman.

Introduction of Honor Guests.

Introduction of Convention Chairman, Mrs. E. J. Morhous.

Roll Call of Delegates, Mrs. Rupert W. Powell.

Convention Rules of Order, Mrs. J. Preston Lilly.

Treasurer's Report, Mrs. George Curry.

In Memoriam, Mrs. Dante Castrodale.

Credentials and Registration, Mrs. James W. Hamilton.

Keynote Address—Mrs. William Mackersie, President, Woman's Auxiliary to the American Medical Association.

Recommendations from Pre-Convention Board Meeting—Mrs. Robert R. Pittman.

New Business and Announcements.

Report of Revision Committee, Mrs. William A. Thornhill, Jr.

Report of Nominating Committee, First Reading, Mrs. G. Thomas Evans.

Election of 1961 Nominating Committee.

Reports of Officers:

President—Mrs. Robert R. Pittman.
President Elect—Mrs. Clark K. Sleeth.
First Vice President—Mrs. Vernon L. Dyer.
Second Vice President—Mrs. Myer Bogarad.
Third Vice President—Mrs. John F. Morris.
Fourth Vice President—Mrs. P. A. Tuckwiller.
Treasurer—Mrs. George A. Curry.
Recording Secretary—Mrs. Rupert W. Powell
Corresponding Secretary—Mrs. James W. Hamilton.
Parliamentarian—Mrs. J. Preston Lilly.

Reports of Standing Committees

AMEF—Mrs. G. C. Hedrick, Jr.
Archives—Mrs. Herbert N. Shanes.
By-Laws and Handbook—Mrs. William A. Thornhill, Jr.
Civil Defense and Safety—Mrs. Charles L. Leonard.
Community Service—Mrs. George Lemon.
Convention—Mrs. E. J. Morhous and Mrs. Harvey A. Martin.
Editor, State News Bulletin—Mrs. L. Dale Simmons.
Circulation Manager—Mrs. Andrew J. Weaver.
Finance—Mrs. Harry E. Beard.
Legislation—Mrs. Earl S. Phillips.
Members-at-Large—Mrs. C. L. Howard.
Mental Health—Mrs. Robert Tchou.
Organization—Mrs. Clark K. Sleeth.
National Bulletin—Mrs. C. R. Davisson.
Necrology—Mrs. Dante Castrodale.
Nutrition—Mrs. C. Stafford Clay.
Program—Mrs. A. C. Chandler.
Publicity—Mrs. John W. Hash.
Paramedical Careers—Mrs. Howard G. Weiler.
Southern Medical Councilor—Mrs. Ross P. Daniel.
Rural Health—Mrs. William R. McCune.

Presentation of County Presidents:

Boone—Mrs. O. D. MacCallum.
Cabell—Mrs. Lee F. Dobbs.
Central West Virginia—Mrs. Elden H. Pertz.
Eastern Panhandle—Mrs. Curtis G. Power.
Fayette—Mrs. R. S. Birckhead.
Greenbrier Valley—Mrs. Lee B. Todd.
Hancock—Mrs. George Rigas.
Harrison—Mrs. James A. Thompson.
Kanawha—Mrs. George Miyakawa.
Logan—Mrs. Ray M. Kessel.
Marion—Mrs. O. M. Goodwin.
McDowell—Mrs. Dante Castrodale.
Mercer—Mrs. Gordon L. Todd, Jr.
Mingo—Mrs. W. W. Scott.
Monongalia—Mrs. Hubert A. Shaffer.
Ohio—Mrs. John G. Thoner.

Potomac Valley—Mrs. H. Luke Eye.
Preston—Mrs. Donald P. Brown.
Raleigh—Mrs. F. Vivan Lilly.
Summers—Mrs. Jack D. Woodrum.
Taylor—Mrs. Paul P. Warden.
Wood—Mrs. Edward Shupala.
Wyoming—Mrs. Mario Cardenas.

## THURSDAY AFTERNOON

12:30—Luncheon and Fashion Show by Alanson's of The Greenbrier and Delray Beach, Florida. Music by William Fearnley (Mural Dining Room).

2:30—Bridge and Canasta Party in the Trellis Lobby.

3:00—Naturalist Tour.

Tour of Alabama Arts Colony.

Visit the Exhibits. Chesapeake Hall open until 5 o'clock.

## THURSDAY EVENING

10:00-12:00—Dancing in the Ballroom.

West Virginia Day at the State Fairgrounds at Fairlea.

## FRIDAY MORNING
### August 26

8:00—Past President's Breakfast. Mrs. G. Thomas Evans, Immediate Past President, *presiding* (Director's Room).

9:30—General Session. Mrs. Robert R. Pittman, President, *presiding* (Fillmore and Van Buren Rooms).

Invocation and Pledge of Loyalty, Mrs. Charles L. Goodhand.

Introduction of Honor Guests.

Roll Call—Mrs. Rupert W. Powell.

Report of Reading Committee—Mrs. Ralph J. Ryan.

Convention Announcements—Mrs. E. J. Morhous.

Guest Speaker: Mrs. John M. Chenault, President, Woman's Auxiliary to the Southern Medical Association.

Reports of Convention Committees:
Finance—Mrs. Harry E. Beard.
Resolutions—Mrs. Ross P. Daniel.

Credentials and Registration—Mrs. James W. Hamilton.

Press and Publicity—Mrs. John W. Hash.

"West Virginia's First University Program in Nursing."—Dorothy Mae Major, Dean, WVU School of Nursing.

Report of Nominating Committee—Mrs. G. Thomas Evans, Chairman.

Election of Officers.

Installation of Officers—Mrs. William Mackersie.

Presentation of President's Pin and Gavel—Mrs. Robert R. Pittman.

Presentation of Past President's Pin—Mrs. G. Thomas Evans.

Inaugural Address—Mrs. Clark K. Sleeth.

## FRIDAY AFTERNOON

2:00—Golf and Tennis Tournaments.

Tour of Alabama Arts Colony.

Visit the Exhibits. Chesapeake Hall open until 5 o'clock.

## FRIDAY EVENING

10:00—Entertainment and Dance in the Ballroom. Music by the Meyer Davis Orchestra.

Introduction of Honor Guests.

Awarding of Golf Prizes.

## SATURDAY MORNING
### August 27

10:00—Post-Convention Conference. Mrs. Clark K. Sleeth, President, *presiding* (Fillmore Room).

Executive Board Meeting (Fillmore Room).

## SATURDAY AFTERNOON

3:30—Second and Final Session of the House of Delegates (Theatre).

Address: E. Vincent Askey, M.D., President, American Medical Association.

Introduction of West Virginia's "General Practitioner of the Year."

Introduction of Honor Guests.

All Auxiliary members are invited and urged to attend both sessions of the House of Delegates.

## SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception, honoring the Officers of the West Virginia State Medical Association (Auditorium Terrace).

10:00—Dancing in the Ballroom.

# SCIENTIFIC EXHIBITS

## (Chesapeake Hall and Foyer)

### FUNDAMENTALS IN THE MANAGEMENT OF ASTHMA

Foyer

This exhibit is divided into several sections: Prologue, complications of Asthma, pathogenesis, diagnosis, complications, differential diagnosis and specific management of Asthma. It is pointed out that steroid hormones are being used excessively in the treatment of Asthma, often less hazardous medications will give relief, and that the mortality in Asthma has not decreased since the steroids have been available. An attempt is made to reevaluate certain basic fundamentals in the causes and treatment of Asthma.

Henry D. Ogden, M. D., Marvin Fuchs, M. D., and Lester S. Blumenthal, M. D.

### REJUVENATION OF THE AGED FACE

Foyer

This exhibit illustrates the corrective treatment of patients who demonstrate the appearance of the aged face. The exhibit will show the pre- and post-operative comparison with a description of the technique involved.

Clyde Litton, M. D., D. D. S.

### ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.

Chesapeake Hall

This exhibit consists of display cards and blown-up cartoons which describe and depict some of the problems facing the medical profession and how AAPS works to help solve them. Organization material, which gives the background, principles and objectives of the Association, will be available.

### CONTINUOUS INTRAPLEURAL SUCTION DRAINAGE IN THE MANAGEMENT OF SPONTANEOUS PNEUMOTHORAX

Foyer

This exhibit is a presentation of a course of management which has been established by the authors to eliminate many of the past objections to closed thoracotomy and the maintenance of chest suction with an electrically driven pump. Illustrations show a chest pump being used for cases of unilateral pneumothorax; two chest pumps in cases of bilateral pneumothorax; and in those cases of a large visceral pleural leak the advantages of using two chest pumps on one pleural space. A case presentation. Currently used methods of entering the pleural space in closed thoracotomy is outlined as well as a new system whereby a trocar and catheter sealed in a plastic bag is employed. A photograph of a working model of an experimental chest pump.

Jules F. Langlet, M. D., and Donald R. Baumgardner, R. T.

### DIVISION OF VOCATIONAL REHABILITATION

Chesapeake Hall

This exhibit describes the various medical, psychological, social and vocational services provided by the State Vocational Rehabilitation Division to disabled citizens of working age. These services, constituting the rehabilitation process, are designed to prepare disabled citizens for remunerative employment. Rehabilitation services pictured include physical restoration, medical examination, prosthetic devices, vocational evaluation and training, counseling and guidance, and job placement.

F. Ray Power, Director.

### THE NATIONAL FOUNDATION

Chesapeake Hall

In 1958, the incidence of paralytic polio increased in the United States. It is a simple fact that unless Salk vaccine is administered to large numbers of those who have not yet received it, paralytic polio may again rise in this country. The exhibit presents data on the effectiveness of the present Salk vaccine and outlines a plan to eliminate unvaccinated "soft spots" in this country.

T. Sterling Evans and Michael Hyre, State Representatives.

### HEALTH MOBILIZATION SERVICES REGION III

Chesapeake Hall

This exhibit will illustrate the use of moulages for simulating casualties in first-aid and self-aid training. The technique for making use of such casualties was developed by Maj. James Clark of the Air Force Medical Services School as a method of vitalizing and motivating disaster training. Also on display will be a scale model of the Civil Defense Emergency Hospital showing the ideal plan for setting up the hospital. These 200-bed hospitals, several of which are located in West Virginia, are packaged and stored in prepositioned sites for use following a natural disaster or enemy attack.

Samuel J. Hawkins, Program Consultant.

### SURGERY FOR HEARING

Foyer

This exhibit is designed to demonstrate surgical procedures now in use for restoration of hearing. Otos-

clerosis is stressed, and we have attempted to show the surgical principles by anatomical specimens and drawings, plus the general approach and several procedures used in the middle ear. Actual cases are pictured along with the results shown by pre- and post-operative audiograms.

William C. Morgan, Jr., M. D.

### PHOTOGRAPHY AS A HOBBY BY A PHYSICIAN IN PRACTICE

Foyer

This exhibit is a demonstration on photography as a hobby by a physician in practice. Color transparencies will be on display and will be changed daily.

Leonard M. Eckmann, M. D.

### PRACTICAL PULMONARY FUNCTION STUDIES IN THE PHYSICIAN'S OFFICE

Chesapeake Hall

This exhibit features a demonstration of pulmonary function equipment and its use and interpretation. Pulmonary function studies will also be taken of all interested physicians.

Merle S. Scherr, M. D., and Robert E. Hyatt, M. D.

### JUST HOW DANGEROUS IS RADIATION?

Foyer

Many lay publications have printed articles about radiation hazards which, while technically correct, have developed misleading and unwarranted conclusions. "The loom of truth sometimes spins webs of fancy, and the statistical longbow sends arrows to a great distance." In this exhibit an attempt is made to give a basis for a true evaluation.

Karl J. Myers, M. D.

### WEST VIRGINIA ASSOCIATION FOR MENTAL HEALTH

Chesapeake Hall

This exhibit will outline the activities of the West Virginia Association for Mental Health, and its interest in the development of an adequate mental health program in West Virginia.

Margaret T. Ross, M. D., Executive Secretary.

### AMERICAN CANCER SOCIETY W. VA. DIVISION, INC.

Chesapeake Hall

This exhibit defines early diagnosis and the basis of curability of cancer. It uses three sites, namely, the uterine cervix, the breast and the rectum as examples. It emphasizes the role that early diagnosis plays in cancer control and the need for emphasizing all available means to detect cancer while it is still in a curable stage.

Ralph G. Beveridge, Executive Director.

### W. VA. STATE DEPARTMENT OF HEALTH WEST VIRGINIA HEART ASSOCIATION

Chesapeake Hall

An exhibit depicting the Rheumatic Fever Prevention Program sponsored and financed jointly by the West Virginia Heart Association and the West Virginia State Department of Health. The participation and responsibility of each agency is illustrated to emphasize the importance of this program to the practicing physician and his rheumatic fever patients.

### WEST VIRGINIA TUBERCULOSIS AND HEALTH ASSOCIATION

Chesapeake Hall

"Pulmonary Disease Diagnosis: After the X-Ray, What Would You Do?" This exhibit contains three units, each unit consisting of an x-ray, case history and six possible readings. By means of push buttons that reveal results, the viewer chooses additional diagnostic procedures in an attempt to reach the diagnosis as directly as possible.

Thomas A. Deveny, Jr., Executive Director.

### BUREAU OF DENTAL HEALTH W. VA. STATE DEPARTMENT OF HEALTH

Chesapeake Hall

This exhibit illustrates how dental caries can be minimized in communities having an optimum amount of fluoride in their water supplies. Contrasting illustrations are shown in another area where no fluorides are present. The illustrations are colored slides with accompanying description by tape recording.

### WVU SCHOOL OF MEDICINE

Foyer

The West Virginia University School of Medicine exhibit will feature numerous photographs of the interior of the new Teaching Hospital at the Medical Center in Morgantown.

E. J. Van Liere, M. D., Dean.

# INDUSTRIAL EXHIBITS

## (Chesapeake Hall)

### ABBOTT LABORATORIES
**North Chicago, Illinois**

Booth 10

Members and guests of the West Virginia State Medical Association will be cordially welcomed at Abbott Laboratories' exhibit of leading specialties and new products. Our representatives will be available at the exhibit to give information on the products and to answer any questions you may have.

### THE BAKER LABORATORIES, INC.
**Cleveland, Ohio**

Booth 16

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding are on display. Baker representatives will be glad to discuss the benefits of Baker Milk products which provide all the normal dietary requirements plus a reserve for stress situations.

Representatives: Robert J. Porter and C. W. Mathias.

### BURROUGHS WELLCOME & CO. (U.S.A.) INC.
**Tuckahoe, New York**

Booth 32

The extensive research facilities of Burroughs Wellcome and Company, both here and in other countries, are directed to the development of improved therapeutic agents and techniques. An informed staff will be at our booth to discuss our products and latest developments. New products will include "Actifed" a potent antihistaminic and decongestant that has been found effective in a significant percentage of cases of allergic rhinitis in patients failing to respond to antihistaminics alone. The latest developments in our "Cortisporin" and "Neosporin" products will also be available for your inspection.

Representatives: H. F. Niemeyer, F. B. Vance and J. P. McKay.

### CENTER LABORATORIES
**Port Washington, New York**

Booth 3

Center Laboratories offers the physician a complete allergy service. Stable, potent extracts standardized on a protein nitrogen, total nitrogen or weight/volume basis both for diagnosis and therapy are presented along with a complete line of office and laboratory accessories. Specialized equipment for the preparation of extracts will be demonstrated, and technical problems in the preparation and standardization of extracts will be discussed by our technical representatives. Your comments and inquiries are solicited.

Representatives: Thelma H. Center and J. George Center.

### CIBA PHARMACEUTICAL PRODUCTS, INC.
**Summit, New Jersey**

Booth 55

Ismelin is a new Ciba antihypertensive indicated in advancing hypertension. Alone, or in combination, it has lowered blood pressure effectively in 80 to 90 per cent of patients. Ismelin affords a new way to control hypertension: Since it acts at the site of arteriolar blood pressure regulation—that is, the nerve-arteriole junction—Ismelin has no central or parasympathetic effects. Ciba representatives will be glad to discuss this and other Ciba products.

### THE COCA-COLA COMPANY
**Atlanta, Georgia**

Booth 58

Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Clifton Forge, Virginia, and the Coca-Cola Company.

### CORECO RESEARCH CORPORATION
**New York City**

Booth 21

The Coret Camera embodies the principle of electronic flash and constant automatic control of such factors as distance, aperture, field, and exposure. Now, for the first time, Coreco offers a completely automatic professional clinical camera purposely designed to achieve the ultimate in surface, intra-oral, and intratubular photography. Because of the simplicity of operation, even an inexperienced doctor or nurse can achieve consistently perfect color transparencies.

Representative: William Zimmerman.

### DESITIN CHEMICAL COMPANY
**Providence, Rhode Island**

Booth 12

Desitin Ointment: for treatment of burns, ulcers, diaper rash, abrasions, etc.; Desitin Powder: relieves chafing, sunburn, diaper rash, etc.; Desitin Suppositories and Rectal Ointment: relieve pain and itching in uncomplicated hemorrhoids, fissures; Desitin Baby Lotion: protective, antiseptic; Desitin Acne Cream: a nonstaining, flesh-tinted "Medicream" for the treatment of Acne Vulgaris; Desitin Cosmetic and Nursery Soap:

supermild; Desitin Suppositories with Hydrocortisone: prompt response to inflammatory conditions in proctitis, severe pruritus, edema.

Representative: Jack Dinin.

### DOHO CHEMICAL CORPORATION
**New York City**

Booth 11

The Doho exhibit will feature Auralgan for otitis media and removal of cerumen; Otosmosan, fungicidal and bactericidal in the suppurative and aural dermatomycotic ears; Rhinalgan, the decongestant free from systemic or circulatory effect; Larylgan, throat spray and gargle for infectious and non-infectious sore throat involvements; Rectalgan, for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing; Dermoplast, an Aerosol spray for surface pain, burns and abrasions, and obstetrical and gynecological use.

### EATON LABORATORIES
**Norwich, New York**

Booth 9

Altafur® (brand of furaltadone), the first nitrofuran effective orally in systemic bacterial infections. High clinical efficacy in pneumonias-bronchiolitis, bronchitis, tonsillitis and otitis media; also in soft tissue infections, cellulitis and abscess, surgical wound infections and infected lacerations.

Representatives: Phillip Read and Thomas Haught.

### ENDO LABORATORIES, INC.
**Richmond Hill, New York**

Booth 36

Endo Laboratories presents the following therapeutic preparations: Coumadin®, the original and only Warfarin Sodium responsible for establishing this drug as "the best anticoagulant available today," provides full-range anticoagulation parenterally or orally, and permits short and long-term predictable therapeutic cover —with fewer "escapes" and less frequent prothrombin time tests. Numorphan®,—14 hydroxydihydromorphinone, the analgesic with wide clinical acceptance, provides effective and lasting relief of pain. Thorough analgesia follows within 5-10 minutes after intramuscular injection. Percodan®, and Percodan-Demi®, oral analgesics, provide rapid onset of action (within 15 minutes) and prolonged duration (5 to 7 hours) of pain relief—with extremely low constipation index.

Representatives: M. J. Berger and Ralph Sager.

### GEIGY PHARMACEUTICALS
**Yonkers, New York**

Booth 52

Geigy Pharmaceuticals cordially invites members and guests of the Association to visit its technical display. Its original contributions to modern therapy of cardiovascular, rheumatic, psychiatric and metabolic disorders will be presented by representatives in attendance.

Representatives: Frederick B. Cornell, Jr., Brewster M. Robertson and John Bushkar.

### GREAT BOOKS OF THE WESTERN WORLD
**Grand Rapids, Michigan**

Booth 46

The Great Ideas Program, a new advancement in liberal education, is built around the revolutionary Syntopicon. This master-key "Idea-Indexes" all the Great Books, making it possible to find what the great writers and thinkers say about any ideas in minutes. The Program will help business and professional people, students, graduates—or anyone interested in exploring the fascinating world of great ideas.

Representatives: Armin Eastman and Lorraine Eastman.

### HART DRUG CORPORATION
**Miami, Florida**

Booth 5

The Hart Drug Corporation of Miami, Florida, will feature Hartgel H-M-B, antispasmodic, antacid, and sedative; Taludon, antispasmodic and sedative of choice; and Otoral, eardrops widely used for treatment of infections of the external and middle ear. We cordially invite you to visit the Hart booth during the meeting.

Representative: Ernest R. Andrews.

### HOSPITAL & PHYSICIANS SUPPLY COMPANY
**Charleston, West Virginia**

Booth 49

You are cordially invited to visit the Hospital and Physicians Supply Company booth located in space number 49. Our exhibit will consist of the latest in Burdick physio-therapy equipment and the new Dual-Speed Electrocardiograph, new diagnostic instruments by Welch Allyn, Castle sterilizers and many other items. We sincerely thank you for your patronage this past year, and shall look forward to visiting with you again.

Representatives: L. Keith Kloman, Robert E. Lee Frazier, Carl L. Carte, Robert K. Thacker and Gordon H. Davis.

### LEDERLE LABORATORIES
**Pearl River, New York**

Booth 57

You are cordially invited to visit the Lederle booth where our medical representatives will be in attendance to provide the latest information and literature available on our line. Featured will be Declomycin® Demethylchlortetracycline, the most recent contribution to broad-spectrum antibiotic therapy, Aristocort® Triamcinolone, the highly effective, well tolerated corticosteroid, and other products of Lederle research.

Representatives: J. J. Coughlin, B. Cuddy and J. M. O'Donnell.

### ELI LILLY AND COMPANY
**Indianapolis, Indiana**

Booth 17

You are cordially invited to visit the Lilly exhibit located in space number 17. The Lilly sales people in

attendance welcome your questions about Lilly products and recent therapeutic developments.

Representatives: J. M. Capin and H. F. Salsbery.

**THE S. E. MASSENGILL COMPANY**
**Bristol, Tennessee**

Booth 18

Best wishes from Massengill to the West Virginia State Medical Association for a most successful meeting. Should you desire, Massengill service representatives will be on hand at the Massengill booth to discuss with you any Massengill product in which you are interested. The S. E. Massengill Company and its service representatives would like to cooperate, in any way possible to make your meeting a complete success.

Representatives: Norman H. Massengill and L. M. Cobb, Jr.

**McLAIN SURGICAL SUPPLY, INC.**
**Charleston—Charlottesville**

Booth 8

Please stop by our booth and see the Ritter Universal and Procto Tables, Liebel-Flarsheim Self-Calculating BMR, Two-Speed EKG, Ultrasound, Autoclaves, Exam Lights and Scales, along with many other new and interesting items.

Representatives: Jack Schwarz and Dick Hightower.

**MEAD JOHNSON & COMPANY**
**Evansville, Indiana**

Booth 7

The Mead Johnson exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Representatives: Charles E. Derbyshire, John B. Conaway and Thomas E. Wilson.

**MEDICAL ARTS SUPPLY COMPANY**
**Huntington, West Virginia**

Booth 42

You are cordially invited to visit us at our booth. Our representatives will be pleased to have the opportunity to show and discuss with you the latest developments in physio-therapy, surgical instruments, diagnostic and examining room equipment, laboratory supplies and pharmaceuticals.

Representatives: M. L. Clovis and Roy Childers.

**MERCK SHARP & DOHME**
**Philadelphia, Pennsylvania**

Booth 51

A new adrenocortical steroid is featured at the Merck Sharp & Dohme booth. "Decadron" dexamethasone possesses all the basic actions and effects of other glucocorticoids but in different degree. Its anti-inflammatory activity is more potent on a weight basis than any other glucocorticoid. Electrolyte imbalance is not ordinarily a therapeutic problem. "HydroDiuril," a new, orally effective, non-mercurial diuretic-antihypertensive agent is also of interest. This compound is the most potent diuretic agent presently available, equaling or exceeding even the most potent parenteral organomercurials in diuretic activity. Technically trained personnel will be present to discuss these and other subjects of clinical interest.

Representatives: M. S. Robertson and J. W. Bernbrock.

**THE WM. S. MERRELL COMPANY**
**Cincinnati, Ohio**

Booth 39

With MER/29 it is possible to reduce both serum and tissue cholesterol levels with one small capsule daily. Clinical results suggest important medical implications of interest to every practicing physician. Merrell representatives will be pleased to discuss the exciting facts about MER/29 with you.

Representatives: Dorian Cook and Al Vineyard.

**MILLER SURGICAL COMPANY**
**Chicago, Illinois**

Booth 13

See the Miller Electro-scalpel, Mark C Model, Miller Radiotherm, and Surgidyne (Tube & Spark Gap Unit). These cutting, coagulating and desiccating units are calibrated to do the most delicate work as well as light major surgery. Accessories such as snares, coagulator with smoke ejector, suction tubes and grasping forceps also available. Also, a long outstanding line of diagnostic equipment consisting of illuminated otoscopes, ophthalmoscopes, eyespud with magnet, transillumination lamps, headlites, vaginal speculum with smoke ejector and Gorsch designed stainless steel proctoscopes and operating scopes, all sizes with magnification. Available also the variable wall rayostat which converts battery operated equipment to electric.

Representative: William E. Mettler.

**ORTHO PHARMACEUTICAL CORPORATION**
**Raritan, New Jersey**

Booth 1

At booth 1 Ortho is introducing a new monilicidal vaginal cream, Sporostacin. This emollient white cream contains the unique chemical, chlordantoin, which because of its structure has the unusual ability to penetrate the monilial membrane. Clinically proved, Sporostacin Chlordantoin Cream is the treatment of choice in monilial vaginitis. Ortho representatives on hand will be happy to discuss this and their other well-known products with you.

Representatives: Raymond E. Weekley, Jr., John H. Breeden, Jr., and Richard L. Johnston.

**PARKE, DAVIS & COMPANY**
**Detroit, Michigan**

Booth 53

Medical service members of our staff will be in attendance at our booth to discuss Parke-Davis specialties which will be on display.

**PFIZER LABORATORIES**
**Brooklyn, New York**

Booth 15

Professional Service Representatives from Pfizer Laboratories will be pleased to have you in attendance at their booth to discuss the latest products of Pfizer research.

**WM. P. POYTHRESS & COMPANY, INC.**
**Richmond, Virginia**

Booth 2

A cordial welcome awaits you at the Poythress exhibit booth. Synirin, our outstanding new analgesic tablet, will be featured. Also displayed will be Solfoton, Mudrane, Trocinate, Solfoserpine, Panalgesic, and other Poythress specialties. Your requests for literature and trial quantities of Poythress products are sincerely invited.

Representative: Harper A. Gordon.

**ROCHE LABORATORIES**
**Nutley, New Jersey**

Booth 14

Tigan—a new, specific antiemetic agent effective both prophylactically and therapeutically against most clinically significant types of nausea and vomiting. New Librium has rapid and often dramatic therapeutic effects in anxiety and tension as well as certain types of depression. Librium is free from autonomic or extra-pyramidal side effects and is remarkably safe over a wide dosage range.

**ROSS LABORATORIES**
**Columbus, Ohio**

Booth 47

Ross Laboratories, who also manufactures, Similac, features Similac With Iron, a new prepared infant formula supplying 12 mg of ferrous iron per quart of formula. Similac With Iron is designed for use at the time exogenous iron is indicated in infancy to support the usual diet and to provide prophylaxis against iron deficiency during the period of greatest incidence, from 6 to 18 months of life. Some special indications for use are following placental or traumatic blood loss, for prematures and twins, for the pallid, irritable, anorectic infant with an unsatisfactory blood picture and following prolonged infection or diarrhea.

Representatives: Edwin Rader and Don DeBona.

**SANDOZ PHARMACEUTICALS**
**Hanover, New Jersey**

Booth 38

Sandoz Pharmaceuticals cordially invites you to visit our display at space number 38: Mellaril—the first potent tranquilizer with a selective action (i.e. O no action on vomiting centers). This unique action gives specific psychic relaxation with safety at all dosage levels. Plexonal—preferred daytime sedative—relaxant. Superior to both the barbiturates and meprobamates. Fiorinal—a new approach to therapy of tension headache and other head pain due to sinusitis and myalgia. Our representative will gladly answer questions about these and other Sandoz products.

Representative: Issac Phipps.

**W. B. SAUNDERS COMPANY**
**Philadelphia, Pennsylvania**

Booth 33

Our representative will be on hand with the complete Saunders line. Ask him about Kelly.

Representative: Hugh J. McGinn.

**SCHERING CORPORATION**
**Bloomfield, New Jersey**

Booth 6

The Schering exhibit will feature the following products: Miradon, the new oral anticoagulant proved by 5 years' pre-introductory clinical experience; Fulvicin, the first oral antifungal antibiotic for ringworm; Delenar, the new corticoid-muscle relaxant-analgesic that keeps the rheumatic man in action; and Rela, a new muscle relaxant-analgesic that eases sprains, strains and low back pains.

**G. D. SEARLE & COMPANY**
**Chicago, Illinois**

Booth 50

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be our new Aldosterone-Blocking Agent for edema or ascites, Aldactone.

Representative: P. E. Rinderknecht.

**SMITH KLINE & FRENCH LABORATORIES**
**Philadelphia, Pennsylvania**

Booth 35

Our representatives welcome the opportunity to discuss S.K.F. products with you and are ready always to be of help in any way they can. Products featured at this meeting are: (1) Eskatrol® Spansule® capsules, the tranquilizer-anorexigenic for "problem" overweight patients; (2) "Ornade" Spansule® capsules, the unique oral nasal decongestant for treating symptoms of hay fever and other allergies; and (3) Fortespan® capsules, high potency multivitamins—therapeutic formula—in Spansule® sustained release capsules.

### E. R. SQUIBB & SONS
**New York City**

Booth 56

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed. At booth 56, we are pleased to present up-to-date information on these advances for your consideration.

Representatives: M. G. Albaugh, W. E. Zopp and J. L. Sutton.

### STATE MEDICAL ASSOCIATION'S GROUP DISABILITY INSURANCE PROGRAM

Booth 34

The administrator of the Group Disability Insurance Program will provide a brochure describing the plan of the West Virginia State Medical Association's Group Health and Accident and Office Overhead Expense Insurance Programs to visitors at the booth. The fundamental advantage of the group insurance plan is service here in West Virginia. This is an opportunity to meet the administrator—he is the man who will pay your claim.

Representatives: J. Banks Shepherd and A. B. Daniel.

### THE STUART COMPANY
**Pasadena, California**

Booth 54

The Stuart representatives extend a cordial invitation to doctors attending this meeting to discuss with them the latest developments of The Stuart Company.

### THE THERMO-FAX BRAND COPYING MACHINE DEALERS OF WEST VIRGINIA

Booth 37

The Thermo-Fax Copying Products, manufactured by Minnesota Mining and Manufacturing Company, are widely used by the medical profession in preparing itemized patient statements. With this process you can prepare as many as 1,000 itemized statements in a single morning. Please stop by our booth and grant us a few minutes to prove that this product of 3M research can ease your work load, increase income and efficiency just as it has done for so many other doctors.

Representatives: Hugh C. Meier and Dick Kelley.

### WARNER-CHILCOTT LABORATORIES
**Morris Plains, New Jersey**

Booth 4

Nardil—safe, new, rapidly effective treatment for true (endogenous) depression, restores depressed and despondent patients to reality with no toxic effect on blood, liver or kidney. Gelusil—the physician's antacid —for the relief of gastric hyperacidity and management of peptic ulcer. Clinically superior because it is non-constipating. Ideally suited for the peptic ulcer patient because it contains no laxative which might cause irritation and hypermotility. Peritrate—painful seizures often create fear in the patient with angina pectoris. Attacks can be controlled and fear arrested by prophylactic management with Peritrate, the long-acting coronary vasodilator. Prescribed on a regular daily dosage schedule, Peritrate increases coronary circulation and lessens the frequency and severity of attacks. In addition, nitroglycerin dependence is often dramatically reduced and exercise tolerance increased.

### WEST VIRGINIA LIFE INSURANCE COMPANY
**Huntington, West Virginia**

Booth 31

Several thousand West Virginians join in presenting the Professional Protection Policy of the West Virginia Life Insurance Company, a wholly owned subsidiary of the West Virginia Insurance Management Corporation. The unusual features of this Professional Protection Policy of the West Virginia Life Insurance Company are detailed in the brochure that tells of protection of West Virginians by West Virginians. Meet some of the principals of this West Virginia owned company that was planned and designed for your protection and development of our State.

### WINDSOR ASSOCIATES

Booth 41

Windsor Associates, an independent marketing research organization, specializing in pharmaceutical problems, will be interviewing practicing physicians on their use and preference of drug therapy. We cordially invite you to visit us at our booth.

### THE MAX WOCHER & SON COMPANY
**Cincinnati, Ohio**

Booth 20

Wocher's, your complete supply source since 1837, will feature their quality surgical instruments known the world over, as well as many of their specialties for the physicians' offices.

Representative: L. E. Boehme.

# 93RD ANNUAL MEETING

of the

# *West Virginia State Medical Association*

## *The Greenbrier*

AUGUST 25-27, 1960

# ANNUAL REPORTS

## AMEF Committee

Medical schools in the United States have an annual operating deficit of $10,000,000. Each year since 1951 the American Medical Education Foundation has received and distributed about $1,000,000 in unrestricted grants to approved medical schools; however, at least twice that amount is needed.

Experience all over the nation has shown that programs to solicit voluntary contributions, no matter how successful, have fallen far short of the goals which organized medicine might reasonably be expected to attain. Our own state is a good example. In recent years 12 per cent of the physicians in West Virginia have contributed an average of about $35 each year, for an annual average of about $7,500.

Many of the leaders in AMEF have had the strong conviction that the states should provide a convenient way to encourage regular contributions by all physicians. To this end, eight states have instituted dues increases for AMEF of from $5 to $20; five states and the District of Columbia have established voluntary dues increases of from $5 to $25; and four state medical associations have requested individual contributions for specific amounts ranging from $25 to $35.

With these facts in mind, your AMEF Committee has this year directed its efforts toward the introduction of a resolution and a change in the By-Laws which would effect an increase of $10 in the annual dues of the West Virginia State Medical Association. Such a dues increase would approximately double our yearly contribution to AMEF.

The need is great. The time is now.

Respectfully submitted,

W. L. Neal, M. D.,
*Chairman.*

Huntington,
July 1, 1960.

## Committee on Aging

The Committee on Aging met at the Daniel Boone Hotel in Charleston on March 20, 1960. An extensive discussion of the so-called problems of aging was held and the members of the committee expressed their opinions concerning the aging in their areas.

Conclusions were reached and recommendations made as follows:

1. It is strongly urged that county societies appoint committees on aging;
2. That county chairmen be kept informed of what is done by the state committee;
3. That visiting nurses be given encouragement by each local committee;
4. That we all encourage the establishment of services for shut-ins: meals on wheels, etc.;
5. That our committee encourage the establishment of convalescent and nursing homes and that local county societies encourage the same locally as much as possible;
6. That we emphasize the need for abolishment of restrictions on income for social security beneficiaries; and
7. That we reaffirm our belief that Forand-type legislation would not solve the problem of medical care for the aging.

The chairman and several members of the committee attended the AMA-sponsored conference on aging in Baltimore, March 30-31, 1960 and the paper presented there by your chairman has been published in *The Journal.*

The chairman and at least one other member of the committee attended the AMA meeting on aging held in Chicago on April 23rd. A report of this meeting was made briefly as an editorial in *The West Virginia Medical Journal.*

It is the hope of this committee that Congress will defer any legislation concerning the aged until after the White House Conference in January, 1961.

Respectfully submitted,

E. Lyle Gage, M. D.,
*Chairman,*
Deane F. Brooke, M. D.,
Eugene S. Brown, M. D.,
N. H. Dyer, M. D.,
Logan W. Hovis, M. D.,
John W. Hash, M. D.,
George F. Evans, M. D.,
J. J. Lawless, M. D.,
D. A. MacGregor, M. D.,
Gordon L. Todd, M. D.,
Walter E. Vest, M. D.,
J. E. Wilson, Jr., M. D.

Bluefield,
July 8, 1960.

## Cancer Committee

The Cancer Committee of the West Virginia State Medical Association met on November 1, 1959 and adopted a program to promote enlargement of facilities for cancer diagnosis and treatment in West Virginia by:

(1) Developing a list of physicians who are willing to do cancer detection examinations in cooperation with the program of the American Cancer Society, West Virginia Division;

(2) Promoting the development of centers for cytology in various parts of the state by encouraging the establishment of training programs for cytologic technicians;

(3) Publishing a list of material on cancer which is available to the physician through the American Cancer Society; and

(4) Asking the State Legislature for an increase in the annual appropriation for the Bureau of Cancer Control of the State Department of Health in order that funds may be adequate for the treatment of indigent cancer patients throughout the year.

The development of the list of physicians who are willing to do either partial or complete cancer detection examinations has proceeded through several stages and will soon be in operation in some sections of the state. The program was approved by the Council of the West Virginia State Medical Association, then by the Executive Committee, and later the Board of Directors of the American Cancer Society, West Virginia Division. The Professional Educational Committee of the Division is working on the details of the plan. Two of the county medical societies have approved the program and letters have gone to the secretaries of the other societies asking that the plan be acted upon at an early date.

As soon as the county medical societies approve the cancer detection program, letters and descriptive literature will be mailed to each individual physician asking him to participate. Following receipt of his assent, examination forms and other material will be furnished him by the Cancer Society.

A sub-committee on cytology has been appointed and it is now working on the details of a program designed to enlarge the cytologic facilities in the state.

The program which has been initiated is rather extensive and has many ramifications and, therefore, will take considerable time, but it seems that it should progress more rapidly in the near future since most of the ground work has now been laid.

Respectfully submitted,

Hu C. Myers, M. D.,
*Chairman,*
Chauncy B. Wright, M. D.,
W. W. Huffman, M. D.,
Charles T. Lively, M. D.,
Carl B. Hall, M. D.,
John T. Jarrett, M. D.,
Herman Seltz, M. D.,
Robert J. Reed, Jr., M. D.,
John W. Trenton, M. D.,
Peter Ladewig, M. D.

Philippi,
July 1, 1960.

## Insurance Committee

Our State Association Group Insurance program has been in operation for over ten years. Today there exists a firmly established plan that provides sound insurance at low group rates. Our group insurance is administered here in the state. Time has clearly shown the advantage of this "on the ground service" when you have a claim or questions arise concerning your coverage.

Briefly outlined below are the coverages that are now available:

### Disability Insurance

The disability program includes three basic plans:

1.—Long Term Disability Insurance. This policy pays weekly income for as long as five years in event of illness and for Lifetime in event of accident. An alternate to this policy (and at a correspondingly lower premium) is a policy that pays lifetime accident and two years sickness. Both policies provide $5,000 accidental death. The contract is clear cut with no hidden clauses or ambiguities. Approximately 60 per cent of eligible physicians carry this coverage.

2.—Family Catastrophe Hospitalization. This policy pays up to $10,000 for major illness or serious accident. It may be written to include your entire family with up to $10,000 protection on each person covered. The policy provides a choice of deductibles, either $100 deductible or, at a correspondingly lower premium, $500 deductible, per claim. The policy covers all costs of hospital bed and board and miscellaneous hospital charges. It covers 75 per cent of nursing care in the hospital rendered by licensed graduate nurses. Also available is an optional rider that provides a surgical schedule and doctor calls. This plan appeals particularly to the younger physician. At this time all eligible physicians of our Association carry this coverage.

3.—Office Overhead. This policy pays your office expenses, rent, receptionist, bookkeeper, etc., when you are disabled. The practical necessity of keeping our offices open during a period of disability is a generally accepted fact, but it is also a substantial burden. This policy pays the cost. Because of the large percentage of our physicians working in clinics or in partnerships in which this type of insurance is not of particular interest, we have only 25 per cent coverage among our eligible physicians. A primary advantage of this plan is that the premium paid is tax deductible.

### Life Insurance Program

A life insurance policy especially designed to the needs of a physician is also available. It features low cost protection and full conversion privileges. It affords an excellent opportunity for the young physician to create an estate and protect his family at minimum cost.

### On the Ground Service

As mentioned earlier, a fundamental advantage of our State Medical Association plan is that it is administered here in the state. Revisions and improvements to the plan are under the jurisdiction of Council, subject to approval of the House of Delegates. Service is rendered by the appointed resident administrator. He provides our members "on the ground service" and is always available for personal consultation. He goes wherever and whenever his services are needed. He negotiates with the underwriting company in behalf of our members. He renders qualified service and attention to our members. He travels over the state enrolling new members, answering inquiries, serving claims and generally maintaining the efficiency of the operation of the plan. Time has clearly shown the advantage of this personal service in the administration of the Association Group Program.

Our State Medical Association was one of the first in the country to adopt group insurance on the state level for the benefit of our members. This group has been in operation for over ten years. The coverage has been revised and improved several times. Each time the

limits have been increased and the period for which benefits are payable extended. Today, there exists a well ordered, firmly established plan that serves our members adequately and well.

Your committee has recently been studying the problen of "Breach of Contract" provision in your malpractice insurance. The committee is indebted to the Kanawha Medical Society for its intensive study of this problem but at this time there is still a great deal of confusion between the various carriers as to the interpretation of this clause. However, your committee is working on this problem and a more complete report will be submitted at a later date.

For several years the idea of a group annuity has interested your Insurance Committee but all endeavors to find a group annuity which would give an advantage to the members of our Association over individual participation have not been successful. Your committee is still working on this problem.

Respectfully submitted,

Charles A. Hoffman, M. D.,
*Chairman.*

Huntington,
July 1, 1960.

## Committee on Maternal Welfare

The Maternal Welfare Committee of the West Virginia State Medical Association had two meetings during the past year, the first on December 6, 1959 at the Chancellor Hotel in Parkersburg where Abstracts on eleven maternal deaths were reviewed and the second on June 5, 1960 at the Daniel Boone Hotel in Charleston where Abstracts on nine maternal deaths were reviewed. The findings and conclusions about these maternal deaths are the basis of this report.

The Chairman expresses his appreciation to all members of the Committee and to the State Department of Health for the splendid cooperation during the past year, for without their valuable assistance in the compilation of the necessary information and data, the function of the committee would be markedly curtailed.

The Chairman also expresses appreciation to the interested physicians, the State Director of Health, the Director of Maternal and Child Health and the hospital administrators who are cooperating with the committee on this study. The State Director of Health has issued a mandatory ruling requiring all hospital administrators to report all maternal deaths to the Director of Maternal and Child Health within 24 hours of death. This facilitates the gathering of data from the interested physicians while the details are still fresh in memory, and has enabled the committee to secure photostats of hospital records and autopsies much earlier than through the method used in the past. This results in many more data-complete abstracts of maternal deaths, which was impossible in the past, making it a valuable study for the committee and supports the statistical conclusions of this study.

The Committee maintains liaison with the Maternal Welfare Committee in Ohio, Iowa, Massachusetts, and the District of Columbia, receiving reprints and abstracts of their statistical studies. This has resulted in a nucleus of a library on this specialty study. The level of obstetric practice in West Virginia compares favorably with the results in the "pilot" states where these studies have been a part of the maternal welfare program of the medical societies and the State Health Departments for years.

The questionnaire has been received by the interested physicians in good faith and many of our physicians send in complete office records, hospital charts and copies of autopsies, resulting in a complete and valuable case study for committee review. It is the hope and goal of this committee that *all* of the physicians in the state who practice obstetrics and have a maternal death will receive the questionnaire in good faith, and forward complete data on these cases for committee review. These reports enable the committee to evaluate each maternal death as to cause and responsibility. This is a rewarding exercise for each committee member and requires study and research, but this is increasing the individual knowledge of each member by giving him an appreciation of the expanding scope of obstetric complications.

All data pertaining to any maternal death is considered confidential and no member of the committee, including the Chairman, has access to the identity of the interested physician, the interested hospital or the patient's name. The secretary prepares all abstracts with the help of the personnel in the Division of Maternal and Child Health. This permits an impersonal evaluation of the data, the case is discussed on its own merits and criticism is not influenced by personality interference. The interested physician is informed by letter of the committee's findings relating to his maternal death.

### Tabulated Analysis of Committee's Work

The following tables contain a tabulated analysis of the work of the committee for the current year and for the preceding five years and are submitted for the information and study by the members of the West Virginia State Medical Association.

The latest statistical survey available for West Virginia between maternal deaths and births is for 1958:

| | |
|---|---|
| Total births | 44,428 |
| Maternal Deaths | 20 |
| Maternal Death Rate | .4 |

**MATERNAL DEATHS, JUNE, 1959—JULY, 1960**

**I. Classification of Maternal Deaths Reviewed by Committee During the Period of June, 1959-July, 1960.**

| *Year* | *Obstetric* | *Non-Obstetric* |
|---|---|---|
| 1959-1960 | 20 | |

**II. Direct Cause of Obstetric Deaths (1959-1960)**

| *Cause of Death* | *No.* | *% of Total* |
|---|---|---|
| Anesthesia (1 hospital & 1 home) | 2 | 12.5 |
| Hemorrhage | 7 | 43.9 |
| Toxemia | 4 | 25. |
| Infection | 1 | 6.2 |
| Pulmonary Embolism | 1 | 6.2 |
| Drug Reaction | 1 | 6.2 |
| Total | 16 | 100. % |

**III. Indirect Cause of Death (1959-1960)**

| *Cause of Death* | *No.* | *% of Total* |
|---|---|---|
| Cardiac Arrest | | |
| Mitral Stenosis | 1 | 25. |
| Acute Congestive Heart Failure | 1 | 25. |
| Congenital Developmental Defect | | |
| Cavernous hemangioma of the splenic vein | 1 | 25. |
| Uremia | 1 | 25. |
| Total | 4 | 100. % |

**IV. Obstetric Deaths by Preventability (1959-1960)**

| *Classification* | *No.* | *% of Total* |
|---|---|---|
| Preventable by Patient and Family | 3 | 15. |
| Preventable by Physician | 8 | 40. |
| Preventable by Patient & Physician | 1 | 5. |
| Preventable by Hospital | 1 | 5. |
| Preventable by Physician, Hospital and Patient | 1 | 5. |
| Preventable—No Factor Recognized | 1 | 5. |
| Non-Preventable | 5 | 25. |
| Total | 20 | 100. % |

**V. Obstetric Deaths by Place of Delivery (1959-1960)**

| *Place* | *No.* | *% of Total* |
|---|---|---|
| Hospital | 16 | 80. |
| Undelivered | | |
| Hospital | 3 | 15. |
| Home | 1 | 5. |
| Total | 20 | 100. % |

**VI. Obstetric Deaths by Race (1959-1960)**

| *Race* | *No.* | *% of Total* |
|---|---|---|
| White | 18 | 90. |
| Colored | 2 | 10. |
| Total | 20 | 100. % |

**VII. Obstetric Deaths by Age Group (1959-1960)**

| *Age Group* | *No.* | *% of Total* |
|---|---|---|
| 15-19 | 2 | 10. |
| 20-24 | 4 | 20. |
| 25-29 | 6 | 30. |
| 30-34 | 3 | 15. |
| 35-39 | 2 | 10. |
| 40-44 | 2 | 10. |
| 45 and over | 1 | 5. |
| Total | 20 | 100. % |

**VIII. Obstetric Deaths by Parity (1959-1960)**

| *Parity* | *No.* | *% of Total* |
|---|---|---|
| Primipara | 4 | 20. |
| 1-3 | 5 | 25. |
| 4-6 | 6 | 30. |
| 7 and over | 5 | 25. |
| Total | 20 | 100. % |

**IX. Obstetric Deaths by Weeks of Gestation (1959-1960)**

| *Weeks of Gestation* | *No.* | *% of Total* |
|---|---|---|
| Less than 28 weeks | 3 | 15. |
| 28-33 | 6 | 30. |
| 34-39 | 10 | 50. |
| 40 plus | | |
| Unknown | 1 | 5. |
| Total | 20 | 100. % |

**X. Obstetric Deaths by Operative Procedure (1959-1960)**

| *Procedure* | *Preventable* | *%* | *Non-Preventable* | *%* |
|---|---|---|---|---|
| Caesarean | 3 | 20. | 1 | 20. |
| Post-mortem Caesarean | 1 | 6.7 | 1 | 20. |
| Forceps | 1 | 6.7 | | |
| Other | 1 | 6.7 | | |
| None | 5 | 33.3 | 3 | 60. |
| Not Delivered | 4 | 26.6 | | |
| Total | 15 | 100. % | 5 | 100. % |

**XI. Obstetric Deaths by Type of Consultation (1959-1960)**

| *Type of Consultant* | *No.* | *% of Total* |
|---|---|---|
| Obstetrician | 6 | Percentages cannot be calculated because some patients were seen by more than one consultant. But it is significant that 30% had no consultation. |
| Surgeon | 5 | |
| General Practitioner | 5 | |
| Interne | 1 | |
| None | 6 | |
| Other | 4 | |
| Total | 27 | |

**XII. Interval Between Delivery and Death (1959-1960)**

| *Time Interval* | *No.* | *% of Total* |
|---|---|---|
| Under one day | 10 | 50. |
| 1 day - 1 week | 3 | 15. |
| 1 week plus | 1 | 5. |
| Undelivered | 4 | 20. |
| Post-mortem Caesarean | 2 | 10. |
| Total | 20 | 100. % |

**XIII. Outcome of Pregnancy in Obstetric Deaths (1959-1960)**

| *Type of Outcome* | *No.* | *% of Total* |
|---|---|---|
| Stillbirth | 5 | 25. |
| Livebirth—full term | 8 | 40. |
| Livebirth—premature | 3 | 15. |
| Undelivered | 4 | 20. |
| Total | 20 | 100. % |

**XIV. Medical Deaths Associated with Pregnancy—None**

**XV. Analysis of Obstetric Death Certificates (1959-1960)**

| | *No.* | *% of Total* |
|---|---|---|
| Death Certificate Correct and Complete | 17 | 85. |
| Death Certificate Incorrect | 2 | 10. |
| No Data Available | 1 | 5. |
| Total | 20 | 100. % |

**XVI. Autopsies Done on Obstetric Deaths (1959-1960)**

| | *No.* | *% of Total* |
|---|---|---|
| Autopsy Obtained | 7 | 35. |
| Autopsy Not Obtained | 12 | 60. |
| Unknown | 1 | 5. |
| Total | 20 | 100. % |

## MATERNAL DEATHS JUNE 1955—JULY 1960

### I. Classification of Maternal Deaths Reviewed by Committee During the Period of June, 1955-July, 1960

| Year | Obstetric | Non-Obstetric Med. | Non-Obstetric Surg. | Combined Ob. & Med. | Combined Ob. & Surg. |
|---|---|---|---|---|---|
| 1955-1956 | 12 | 1* | .... | 3**** | .... |
| 1956-1957 | 15 | .... | .... | .... | .... |
| 1957-1958 | 14 | 2** | .... | .... | .... |
| 1958-1959 | 7 | 2*** | .... | .... | .... |
| 1959-1960 | 20 | .... | .... | .... | .... |
| Totals | 68 | 5 | .... | 3 | .... |

*Insulin Shock

**1 Viral hepatitis death; 1 Subarachnoid hemorrhage.

***1 Adrenal cortico syndrome; 1 Perforation of gastric ulcer.

****1 Transfusion reaction; 1 Anesthetic death; 1 Diabetic with eclampsia insulin reaction.

### II. Direct Cause of Obstetric Deaths (1955-1960)

| *Cause of Death* | *No.* | *% of Total* |
|---|---|---|
| Hemorrhage | 32 | 50. |
| Toxemia | 12 | 18.8 |
| Infection | 9 | 14.1 |
| Pulmonary Embolism | 3 | 4.8 |
| Complications following Caesarean | 1 | 1.5 |
| Anesthesia | 2 | 3.1 |
| Drug Reaction | 1 | 1.5 |
| Other* | 4 | 6.2 |
| Totals | 64 | 100. % |

*1 Hypertensive C. V. Disease; 1 Shock-Anesthesia, Transfusion reaction; 1 Cardiac Failure-Pulmonary Edema; 1 Hyperemesis Gravidarum.

### II-b. Indirect Causes of Obstetric Deaths (1959-1960)

| *Cause of Death* | *No.* | *% of Total* |
|---|---|---|
| Cardiac Arrest | | |
| Mitral Stenosis | 1 | 25. |
| Heart Failure | 1 | 25. |
| Congenital Developmental Defect | | |
| Cavernous hemangioma of the splenic vein | 1 | 25. |
| Uremia | 1 | 25. |
| Totals | 4 | 100. % |

### III. Obstetric Deaths by Preventability (1955-1960)

| *Classification* | *No.* | *% of Total* |
|---|---|---|
| Preventable by Patient | 10 | 14.7 |
| Preventable by Physician | 30 | 44.1 |
| Preventable by Physician and Patient | 7 | 10.3 |
| Preventable by Hospital | 2 | 2.9 |
| Preventable by Hospital & Physician | 4 | 5.9 |
| Preventable by Hospital, Patient and Physician | 2 | 2.9 |
| Preventable, no factor recognized | 1 | 1.5 |
| Non-Preventable | 12 | 17.7 |
| Totals | 68 | 100. % |

### IV. Obstetric Deaths by Place of Delivery (1955-1960)

| *Place* | *No.* | *% of Total* |
|---|---|---|
| Hospital | 49 | 72.1 |
| Home | 2 | 2.9 |
| Undelivered | 16 | 23.5 |
| Unknown | 1 | 1.5 |
| Totals | 68 | 100. % |

### V. Obstetric Deaths by Race (1955-1960)

| *Race* | *No.* | *% of Total* |
|---|---|---|
| White | 62 | 91.2 |
| Colored | 6 | 8.8 |
| Totals | 68 | 100. % |

### VI. Obstetric Deaths by Age Group (1955-1960)

| *Age Group* | *No.* | *% of Total* |
|---|---|---|
| 15-19 | 5 | 7.4 |
| 20-24 | 14 | 20.6 |
| 25-29 | 15 | 22. |
| 30-34 | 12 | 17.7 |
| 35-39 | 15 | 22. |
| 40-44 | 5 | 7.4 |
| 45 and over | 2 | 2.9 |
| Totals | 68 | 100. % |

### VII. Obstetric Deaths by Parity (1955-1960)

| *Parity* | *No.* | *% of Total* |
|---|---|---|
| Primipara | 12 | 17.7 |
| 1-3 | 26 | 38.2 |
| 4-6 | 12 | 17.7 |
| 7 plus | 13 | 19. |
| Unknown | 5 | 7.5 |
| Totals | 68 | 100. % |

### VIII. Obstetric Deaths by Weeks of Gestation (1955-1960)

| *Weeks of Gestation* | *No.* | *% of Total* |
|---|---|---|
| Less than 28 | 10 | 14.7 |
| 28-33 | 12 | 17.7 |
| 34-39 | 24 | 35.3 |
| 40 plus | 19 | 27.9 |
| Unknown | 3 | 4.4 |
| Totals | 68 | 100. % |

### IX. Obstetric Deaths by Operative Procedure (1955-1960)

| *Procedure* | *Preventable* | *%* | *Non-Preventable* | *%* |
|---|---|---|---|---|
| Caesarean | 8 | 14.3 | 3 | 25. |
| Postmortem Caesarean | 1 | 1.8 | 1 | 8.3 |
| Forceps | 4 | 7.2 | | |
| Other | 14 | 25. | 1 | 8.3 |
| None | 13 | 23.2 | 7 | 58.4 |
| Not Delivered | 16 | 28.5 | .... | .... |
| Totals | 56 | 100.% | 12 | 100.% |

### X. Obstetric Deaths by Type of Consultation (1955-1960)

| *Type of Consultant* | *No.* | *% of Total* |
|---|---|---|
| Obstetrician | 17 | Percentages cannot be calculated because some patients were seen by more than one consultant. But it is perhaps significant that 35.3% had no consultation. |
| Urologist | 2 | |
| Surgeon | 16 | |
| General Practitioner | 12 | |
| EENT Man | 1 | |
| Interne | 4 | |
| Other | 5 | |
| None | 24 | |
| Unspecified | 2 | |

### XI. Interval Between Delivery and Death (1955-1960)

| *Time Interval* | *No.* | *% of Total* |
|---|---|---|
| Less than 1 day | 30 | 44.1 |
| 1 day - 1 week | 13 | 19. |
| 1 week plus | 6 | 8.8 |
| Undelivered | 16 | 23.5 |
| Unknown | 1 | 1.5 |
| Postmortem Caesarean | 2 | 2.9 |
| Totals | 68 | 99.8 % |

**XII. Outcome of Pregnancy in Obstetric Deaths (1955-1960)**

| *Type of Outcome* | *No.* | *% of Total* |
|---|---|---|
| Fetal Death | 3 | 4.4 |
| Stillbirth | 22 | 32.4 |
| Livebirth—full term | 21 | 30.9 |
| Livebirth—premature | 3 | 4.4 |
| Neonatal | 2 | 2.9 |
| Undelivered | 16 | 23.5 |
| Hydatidiform Mole | 1 | 1.5 |
| Totals | 68 | 100. % |

**XIII. Medical Deaths Associated with Pregnancy (1955-1960)**

1955-1956
Insulin Shock

1956-1957
No medical deaths occurred

1957-1958
Subarachnoid Hemorrhage
Vitral Hepatitis

1958-1959
Adrenal Cortico Syndrome
Perforation of Gastric Ulcer

1959-1960
No medical deaths occurred

**XIV. Analysis of Obstetric Death Certificates (1955-1960)**

| | *No.* | *% of Totals* |
|---|---|---|
| Death Certificate Complete and Correct | 50 | 73.5 |
| Death Certificate Incomplete | 17 | 25. |
| No Data | 1 | 1.5 |
| Totals | 68 | 100. % |

**XV. Autopsies Done on Obstetric Deaths (1955-1960)**

| | *No.* | *% of Totals* |
|---|---|---|
| Autopsy Obtained | 18 | 26.5 |
| Autopsy Not Obtained | 49 | 72. |
| No Data | 1 | 1.5 |
| Totals | 68 | 100. % |

**Definitions**

1. *Maternal Death*—The death of any woman dying of any cause whatsoever while pregnant or within six months of the termination of the pregnancy, regardless of the duration of the pregnancy at the time of the termination or the method by which it was terminated.
2. *Direct Obstetric Cause of Death*—A death resulting from complications of the pregnancy itself, to intervention elected or required by the pregnancy or resulting from the chain of events initiated by the complication or the intervention.
3. *Indirect Obstetric Cause of Death*—A death resulting from disease before or developing during pregnancy (not a direct effect of the pregnancy) which was obviously aggravated by the physiological effect of the pregnancy and caused the death.
4. *Non-Related Cause of Death*—A death occurring during pregnancy or within 90 days of its termination from causes not related to the pregnancy nor to its complication or management.
5. *Factors of Preventability (Avoidability)*—Preventability should be judged in an ideal academic sense. This concept involves three assumptions. First, the physician possessed all the knowledge currently available relating to the factors involved in the death. Second, by experience, he had reached a high level of technical ability. Third, he had available to him all the facilities present in a well-organized and properly equipped hospital. Because of the austerity of these criteria, it is more desirable to determine avoidable factors involved in the death, rather than to label the death as preventable. This allows more specific discussion resulting in better maternal care and reduction of obstetric causes of death.
6. *Factors of Responsibility*—Responsibility should be determined whenever possible and assigned as appropriate to the attending physician, consultant, midwife, hospital, patient, or any combination.

**Factors**

A. *Professional Factors*—These are concerned with cases where there appear shortcomings in diagnosis, judgment, management, and technique, and include failure to recognize the complication or evaluate it properly. They also include instances of injudicious haste, delay or timing of operative intervention, and failure to utilize currently acceptable methods of treatment. Finally, they would include services which were technically inept, and those failures which could have been averted by proper and timely consultation.

B. *Hospital Factors*—These are concerned with facilities, equipment or personnel which are inadequate. In terms of modern obstetrics the hazards of delivery cannot be met successfully unless the hospital provides, (1) a separate, well-directed maternity section; (2) a blood bank; (3) competent 24-hour anesthesia service; (4) suitable X-ray facilities; and (5) adequate 24-hour laboratory facilities.

C. *Patient Factors*—These should be recognized, but never as an excuse for professional inadequacy. They are concerned with death resulting from a complication for which there is generally successful treatment but which the patient denied herself by delaying her initial visit to the physician, delaying obtaining medical care after the symptoms were obvious at a layman's level, or finally, by not following the advice and instructions of her physician.

D. *Undetermined Factors*—If because of inadequate evidence a clear-cut decision cannot be made, yet shortcomings in care are apparent, it would be preferable to indicate that responsible factors are undetermined. An attempt should be made to determine preventability and to locate the responsible factors.

**Committee's Program**

In addition to the review of maternal deaths, the Committee on Maternal Welfare has been actively engaged in advancing the following program which is of vital interest to maternal welfare:

1. The Division of Maternal and Child Health has a full-time Director and a full-time Nurse Consultant. In the past year this team has surveyed the obstetrical and nursery departments of twenty-six hospitals. The Director of Maternal and Child Health, the Obstetric Consultant and the Nurse Consultant have conducted six classes in training midwives, using audio-visual aids, lectures and demonstrations of obstetric techniques during these sessions. A total of forty-three midwives attended these classes.

2. The Division also established prenatal clinics and delivery service for indigent obstetric patients in Camden-Clark Memorial and Logan General Hospitals. A similar clinic is being financed at Charleston Memorial Hospital.

3. The Committee and the Division of Maternal and Child Health are again sponsoring a symposium at the State Medical Association meeting in August, 1960, at

the Greenbrier. Dr. Roger Scott of Western Reserve University School of Medicine, Cleveland, Ohio, will address the West Virginia Ob. and Gyn. Society and conduct the symposium. Dr. Vincent J. Collins of New York Hospital, Bellevue Medical Center, will present a paper on "Anesthesia in the Complications of Pregnancy."

4. The Committee also recommends very strongly that *all* hospitals in the state that have a maternity and nursery service encourage organization of the service, so that basic policies may be determined and followed for the welfare of the mothers, infants and the physicians.

**Analysis of Maternal Deaths**

The Committee presents the following conclusions from the analysis of these maternal deaths:

1. Hemorrhage again heads the list as to cause of death with 43.9 per cent for the current year which is a marked decrease from the 57.1 per cent for last year and the 50 per cent for the five year study. The causes were (1) ruptured ectopic pregnancy; (2) postpartum uterine atony (two cases); (3) ruptured ovarian artery; (4) ruptured uterus-previous section scar; (5) ruptured uterus-traumatic; and (6) postpartum hemorrhage-afibrinogenemia.

2. Toxemia caused 25 per cent of the deaths with four cases of acute fulminating toxemia resulting in eclampsia. Three were attributed to poor patient cooperation and one to physician error.

3. Anesthesia caused 12.5 per cent of maternal deaths. One anesthetic death occurred in the hospital, the other in the home. The hospital death was attributed to the combination of local anesthesia and chloroform; the death in the home was attributed to a reaction to self-administered trilene.

4. The one death from infection was due to a septic abortion.

5. Pulmonary embolism caused one death in premature labor.

6. One maternal death was attributed to cerebral edema, a possible drug reaction to the combination of thorazine and morphine sulfate.

7. There were four maternal deaths due to indirect obstetric causes. The two cases of cardiac arrest were due to (1) mitral stenosis, undiagnosed; and (2) acute congestive heart failure. One death was attributed to uremia, and the other death to a ruptured cavernous hemiangioma of the splenic vein, a congenital defect.

8. Forty per cent of these maternal deaths were preventable by the physician; fifteen per cent were preventable by the patient and family; five per cent were preventable by the patient and the physician; five per cent preventable, no recognized factor; and twenty-five per cent were non-preventable. It is this area of preventability that the Committee can do its greatest good and this is to be accomplished by continuing the educational program, the training of physicians through the delivery service program and by publication and distribution of pertinent information relative to obstetric practice.

**Conclusions**

Finally, the Committee feels that the standards of obstetrical practice are being raised in the state, with closer supervision of the obstetric departments in our hospitals, the establishment of modern laboratory facilities with special emphasis on laboratory procedures peculiar to obstetrics, the establishment of blood banks, the replacement of obsolete equipment with modern facilities, and the eternal education of our physicians who practice this speciality in our state.

The Committee recommends to the West Virginia State Medical Association that the continuity of function and action of the Maternal Welfare Committee be kept intact, and that this can best be accomplished by retaining at least 50 per cent of the committee membership each year.

Respectfully submitted,

Charles L. Goodhand, M. D.,
*Chairman.*

Frederick H. Dobbs, M. D.,
*Secretary.*

July 1, 1960.

## Committee on Medical Education And Scholarships

The Committee on Medical Education and Scholarships had two meetings during the year, one at the West Virginia University Medical Center in Morgantown on April 10, 1960, and the second at the Daniel Boone Hotel in Charleston on May 7, 1960.

The meeting in Morgantown was attended by Carl B. Hall, M. D., Charleston, Chairman; Drs. Martha Coyner, Harrisville, J. P. McMullen, Wellsburg, L. E. Neal, Clarksburg, Russel Kessel and Pat A. Tuckwiller, Charleston, and Maynard P. Pride, Morgantown; and Mr. Charles Lively, Charleston, secretary ex officio.

The meeting was also attended by Elvis J. Stahr, Jr., President of West Virginia University; Dr. Kenneth E. Penrod, Vice President-Medical Affairs, and Dr. Clark K. Sleeth, Assistant to the Dean, WVU School of Medicine, Morgantown.

The first half of the meeting was spent in discussions relating to medical education. This included premedicine, medicine, residency programs and postgraduate medical education.

Particular emphasis was placed upon medical education as it affects students in pre-medicine in all colleges in West Virginia and how the applicants are chosen for Medical School. Also discussed was the length of time it takes to get a medical education and what if anything might be done to shorten this period of time without decreasing the quality of students chosen and the quality of physicians prepared.

No concrete proposals were forthcoming in this respect but all agreed that the length of time it takes to get a medical education is too long and that an effort would be made to remedy this situation in the future.

It was pointed out that all efforts were being made to staff the Medical School with teachers who are capable of making the school second to none.

Residency programs and postgraduate programs discussed are certainly going to be a most important part of the school when it is fully established.

Your Committee was impressed by the sincere efforts of President Stahr and Drs. Penrod and Sleeth to give us all data requested and their untiring cooperation in making the West Virginia University Medical Center an integral part of our overall medical picture.

We finished our discussions on medical education with the firm resolve that we must at all times be ready to cooperate to the fullest extent with these dedicated men of education who are striving to give us a great Medical Center which has so long been needed in West Virginia.

The second part of the meeting was limited to discussions pertaining to scholarships and the evaluation and selection of the recipient of the 1960 scholarship award.

The Committee went on record as recommending to the Council that the sum of $6,000 in the Association's fund earmarked for Medical Scholarships be invested in U.S. Treasury Bonds and placed in an envelope marked for exclusive use in providing medical scholarships.

Larry Hemmings, recipient of the first scholarship award made by the Association in 1958, attended the afternoon session of the Committee and again expressed his gratitude for the award that was made to him two years ago.

The Committee reaffirmed the scholarships for Larry Hemmings and Terry Tallman for the school year 1960-61.

Nine applicants were interviewed and a final decision on the selection of the recipient was deferred until the Committee meeting scheduled for Charleston on May 7, 1960.

On May 7, 1960, the Committee met in Charleston and the following were present: Carl B. Hall, M. D., Chairman, and Drs. J. P. McMullen, Wellsburg, Martha J. Coyner, Harrisville; Maynard P. Pride, Morgantown, and Thomas J. Holbrook, Huntington; and Messrs. Charles Lively and William H. Lively, both of Charleston.

The meeting was also attended by Dr. J. C. Huffman of Buckhannon, President of the State Medical Association, and Dr. Clark K. Sleeth, Assistant to the Dean of the WVU School of Medicine, Morgantown.

The Committee, after reviewing the applications for scholarship and interviewing Mr. Harry G. Buchanan, an applicant who could not be present at the meeting in Morgantown, selected Mr. Harry G. Buchanan of Gilbert, West Virginia, for the 1960 scholarship award. Mr. Paul V. Watson of Charleston was chosen alternate.

It was suggested to the Committee that a recommendation be made to the House of Delegates for the establishment of a fund from which outright gifts may be made to needy students in the Medical School.

It was further recommended that the State Medical Association consider establishing a "West Virginia Day" at the University Medical Center; that an appropriate program be arranged by this Committee in cooperation with the School of Medicine; and that a speaker be provided for the occasion by the State Medical Association through this Committee.

The Committee recommends that the two suggestions be adopted by the House of Delegates.

The members of this Committee have enthusiastically carried out all important problems brought before them, and it is their hope that ways and means may be found to increase the number of scholarships.

Respectfully submitted,

Carl B. Hall, M. D.,
*Chairman,*

L. E. Neal, M. D.,
Thomas L. Harris, M. D.,
Thomas J. Holbrook, M. D.,
Pat A. Tuckwiller, M. D.,
Martha J. Coyner, M. D.,
J. P. McMullen, M. D.,
Maynard P. Pride, M. D.,
Russel Kessel, M. D.,
Sobisca S. Hall, M. D.

Charleston,
July 1, 1960.

## Committee on Syphilis

The continuation of the aim proposed by the Venereal Disease Branch of the Public Health Service for the practical eradication of syphilis in the United States is still the challenge today. Progress against syphilis in West Virginia and the nation since the post-war days has been tremendous. The desire for further progress and control against syphilis in the future depends upon the partnership of our private physicians and the health department.

The Syphilis Committee reports to the West Virginia State Medical Association the splendid cooperation of the private physicians this past year in participating with the State Department of Health. The promotion of the recommendations planned for the 1959 program was accomplished by the team work approach between the private physicians and health department personnel.

Only by complete case reporting and interviewing can we control syphilis and progress toward the ultimate aim of eradication. The epidemiology of syphilis requires much more time and effort than the busy physicians are able to give. The Committee suggests that physicians request the assistance of a specially trained public health representative made available through the State Department of Health to interview and investigate all infectious syphilis cases.

The Committee recommends continuing the educational program of the private laboratories reporting all reactive serologies to the State Department of Health. It recommends further that an article be published in *The West Virginia Medical Journal* on the up-to-date recommended treatment schedules for syphilis.

The Committee has considered the advisability of including the following topics to be published in *The West Virginia Medical Journal* together with the treatment schedules: (1) Drugs furnished by the Health Department; (2) Epidemiological assistance offered; (3) The Treponema Pallidum Immobilization (T.P.I.) testing service as supplied by the State Department of Health; and (4) Follow-up procedures performed on contacts and suspects.

The Committee has evaluated the prevention and control syphilis program within our state, and with continued effort and cooperation of the members of the West Virginia State Medical Association, we will make our contribution in striving for eradication of syphilis in West Virginia and the nation. We welcome any suggestions, recommendations or comments which might be helpful in improving the prevention and control of syphilis.

The chairman takes this opportunity to express his appreciation to the members of the Committee, members of the Association, and State Department of Health personnel for their helpful cooperation and valuable assistance.

We also express our appreciation to the physicians of West Virginia for their continued interest and untiring effort to further the progress against syphilis in the future which will materially benefit our state and nation.

Respectfully submitted,

N. H. Dyer, M. D., M.P.H.,
*Chairman.*

Charleston,
July 7, 1960.

## Conservation of Vision and Hearing

The West Virginia Academy of Ophthalmology and Otolaryngology and the Committee on Conservation of Vision and Hearing of the West Virginia State Medical Association have collaborated on a number of important activities during the past 12 months.

First in importance has been the assistance given to the West Virginia Lions Sight Conservation Foundation in organizing its program of activities.

This Foundation will furnish guidance and coordination for the sight conservation programs of the various Lions Clubs. It will also attempt an ambitious statewide program of:

1. School eye testing for defects.
2. Pre-school eye testing.
3. Obtaining eyes for corneal transplant and assisting in shipment to and from the Eye Banks.
4. Finding of medically indigent cases requiring medical or surgical eye care.
5. Paying the cost of eye care for those cases not otherwise able to secure such care.
6. Furnishing of visual aids for the needy.
7. Education in sight conservation.
8. Providing funds for eye research.
9. Such other sight conservation activities as may be useful.

A unique manual has been prepared and accepted by both groups. This is designed to better coordinate the Lions activities with those of the physician eye specialists. It covers the whole field of sight conservation activities and provides a means for settling problems that arise in the joint efforts of laymen and physicians in combatting blindness. Much national interest has been shown toward this manual since it is the first of its kind. The physicians will help train and instruct persons to carry out the school and pre-school eye screening programs.

Since the services of eye physicians may often be unavailable in smaller communities, an intensive effort is planned to instruct other physicians in the best techniques of removing eyes for corneal transplant. The Lions Sight Foundation will have containers stored at strategic hospitals for shipment of the eyes to the nearest eye bank.

A movie will be shown and instructional material on removal of eyes for corneal transplant distributed at the annual meeting at the Greenbrier.

At the request of the Lions, a glaucoma screening survey was carried out at the West Virginia Lions convention at Bluefield. Four physician eye specialists gave time during the three-day convention to check approximately 400 of the 600 Lions and their wives. Visual acuity, intraocular tension, and inspection of the eyes were recorded by methods approved by the National Society for the Prevention of Blindness.

Glaucoma and suspected glaucoma were found among those tested, the incidence being not significantly different from the national averages of 2 per cent past age 40. Cases suspected of glaucoma were advised to see their eye physician for further studies. Educational literature on glaucoma was handed to every person tested. Examining equipment was furnished largely by the American Optical Company.

The glaucoma survey was so popular that tentative requests have been made to have such testing at every annual Lions Convention.

The Academy has revised its constitution to enable it to cope with present problems, to improve its scientific meetings, and to widen its field of activity and usefulness. A vigorous program is under way to make its scientific meetings compare in interest and attendance with those in more populous states.

Respectfully submitted,

Albert C. Esposito, M. D.,
*Chairman.*

Huntington
July 14, 1960.

# WVU Medical Center
# –News–

FIVE prominent Morgantown physicians have accepted appointment as members of the faculty of the Department of Surgery at the West Virginia University School of Medicine. The physicians and their appointments are as follows:

Dr. Justus C. Pickett, Clinical Professor of Surgery and Chairman of the Division of Orthopedic Surgery; Dr. C. B. Pride, Clinical Professor of Surgery; Drs.

Justus C. Pickett, M. D.

Maynard P. Pride, M. D.

Maynard P. Pride and E. F. Heiskell, Jr., Clinical Assistant Professors of Surgery; and Dr. Carl H. Cather, Clinical Instructor in Surgery and Acting Director of Otolaryngology.

Doctor Pickett was graduated from Dennison University and received his M. D. degree from Western Reserve University School of Medicine. He is a past president of the Monongalia Medical Society and a past chairman of the Section on Orthopedic Surgery of the State Medical Association. He is certified by the American Board of Orthopedic Surgery and is a Fellow of the American College of Surgeons.

Dr. C. B. Pride is a native of Belpre, Ohio, and was graduated from Ohio Wesleyan College. He attended the two-year WVU School of Medicine and received his M. D. degree from Western Reserve University School of Medicine. He has practiced in Morgantown and has been a member of the faculty at the School of Medicine since 1926. He is a member of the Medical Licensing Board of West Virginia.

Dr. Maynard P. Pride, also a graduate of Western Reserve University School of Medicine, has practiced in Morgantown and served on the faculty at the School of Medicine since 1946. He is chief of surgery at Monongalia General Hospital and a member of the surgical staff at Vincent Pallotti Hospital. He is a Diplomate of the American Board of Surgery.

• **Compiled from moteriol furnished by John B. Harley, M. D., Assistont Professor of Pothology ond Public Information Officer at the WVU Medicol Center in Morgantown, W. Va.**

Doctor Heiskell is a native of Morgantown and was graduated from West Virginia University. He attended the two-year WVU School of Medicine and received his M. D. degree from Northwestern University Medical School. He has practiced in Morgantown and served on the faculty at the School of Medicine since 1951.

Doctor Cather, also a native of Morgantown, was graduated from West Virginia University and attended the two-year School of Medicine. He received his M. D. degree from Harvard Medical School and interned at Cincinnati General Hospital. He opened private practice in Morgantown in 1959.

William E. Anderson, M. D.

Carl H. Cather, M. D.

### Instructor in Medicine Appointed

Dr. William E. Anderson of St. Paul, Minnesota, has been appointed Instructor in Medicine at the WVU School of Medicine. He comes to the University from the staff of the VA Hospital in Minneapolis, Minnesota, where he has served for two years under Dr. Edmund B. Flink, recently appointed Professor of Medicine at the School of Medicine.

A native of Mankato, Minnesota, he was graduated from Gustavus Adolphus College in Minnesota and received his M. D. degree from the University of Minnesota Medical School. He served his internship at St. Luke's Hospital, Duluth, Minnesota. In addition to his duties at the VA Hospital, he has been a member of the staff at the University of Minnesota Medical School.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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# The Month in Washington

• From the Washington Office of the American Medical Association.

Congress returned to work this month to take up its unfinished business, including the controversial issue of health care for the aged, an atmosphere dominated by election-year politics. The three-or-four-week tag-end session of Congress loomed as one of the most important meetings in the past decade as far as possible impact on the medical profession is concerned.

The lawmakers are slated to decide whether to embark the Federal government on a course that could threaten the private practice of medicine, or to adopt a voluntary program that would pose no such danger.

The omnibus social security bill approved by the House Ways and Means Committee was easily cleared by the House, 381 to 23, and sent to the Senate Finance Committee, which held two days of hearings. The measure contained a voluntary, Federal-State program for assisting needy aged persons meet their health care costs. Both the Administration and the American Medical Association endorsed the House measure as in keeping with the concept of giving the states prime responsibility for helping their citizens. for aiding those who are most in need of help, and for avoiding the compulsory aspects of health plans involving the social security mechanism.

### Finance Committee Vote Scheduled

A vote by the Finance Committee, headed by Sen. Harry F. Byrd, (D., Va.) was scheduled shortly after the Senate resumes operations in August. Whatever action the Committee takes, however, proponents of schemes such as the Forand Bill to provide a compulsory, federal medical program, promise a determined fight on the floor of the Senate.

In the event Congress should approve a government medicine plan, opponents were counting on a Presidential veto to kill the measure. The Chief Executive repeatedly has asserted in strong language his all-out opposition to any compulsory plan for health care financing.

At the Senate Finance Committee hearing, Arthur S. Flemming, Secretary of Health, Education and Welfare, renewed the Administration's flat stand against the social security avenue to financing health costs. Such a plan, he said, would inevitably lead to pressures for expanding the benefits and lowering or eliminating the age requirement. Under such circumstances, a 15 or 20 per cent social security payroll tax would not be too far off, he said. "We believe it is unsound to assume that revenue possibilities from a payroll tax are limitless."

### Statement by Doctor Larson

Dr. Leonard W. Larson, president elect of the American Medical Association, told the Committee the House bill is the "antithesis of the centralized, socialized, statist approach of the proposals advocating national compulsory health insurance."

"To those critics who call this program modest, we say that fiscal irresponsibility, unpredictable cost and maximum nationalization are not the accepted criteria for good legislation," he testified.

A spokesman for the insurance industry emphasized the "giant strides" that have been made by private health insurance in recent years in covering aged persons. E. J. Faulkner declared that one of the most prevalent and erroneous assumptions is that most of the aged aren't able to contribute to financing their own health care costs.

The Social Security health bills, he said, "would impair or destroy the private practice of medicine, would add immeasurably to our already crushing tax burden, would aggravate our severe public fiscal problems, and would entail other undesirable consequences."

### Keogh-Simpson Bill

The Senate has scheduled debate on another legislative proposal of interest to the medical profession—the Keogh-Simpson bill. Sen. Gordon Allott (R., Colo.) said in a Senate speech that "I believe that this legislation will have the overwhelming support of this body."

The bill, which would encourage retirement savings by the self-employed such as lawyers, small businessmen and physicians, has already been approved by the House. The Senate bill, voted by the Senate Finance Committee, would require participating self-employed to establish retirement plans for their employees.

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The one-story intellect collects facts, the two-story intellect compares, reasons, and generalizes. But the three-story intellect idealizes, imagines, and predicts—with the best illumination coming through the skylight from above.—Oliver Wendell Holmes.

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# Obituaries

### HARLOW RICHARD CONNELL, M. D.

Dr. Harlow Richard Connell, 68, pediatrician of Bluefield, died at a hospital in that city on Wednesday, June 22, 1960, following a short illness. Death was attributed to heart disease.

Doctor Connell was born at Spencerville, Ontario, Canada, July 7, 1892, son of the late William and Mary Brevard Connell. He had his academic education at Queen's University in Canada and received his M. D. degree from the Medical College of Virginia in 1914. He served his internship at the Lewis-Gale Hospital in Roanoke, Virginia, and had postgraduate work at the New York Postgraduate Hospital, the Army Medical School in Paris, France, and the University of Pennsylvania.

He was licensed to practice in West Virginia in 1915 and served a few years as physician for the Houston Coal and Coke Company at Elkhorn and Eckman. He located at Bluefield in 1930, where he continued in the active practice of his specialty until his death.

Doctor Connell served overseas with the Armed Forces during World War I.

He was a member of the Mercer County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by a son, H. R. Connell, Jr., of Rome, Georgia, and a brother, Dr. W. S. T. Connell of Hamilton, Ontario.

* * * *

### FRANK JUDSON MOORE, M. D.

Dr. Frank Judson Moore, 78, of Beckley, died in a hospital in that city on June 19, 1960, following an illness of several weeks' duration.

Doctor Moore was born in Palmyra, Virginia, on May, 9, 1882. He received his M. D. degree from the Eclectic Medical College, in Cincinnati, in 1919, and was licensed to practice in West Virginia in 1920. He had engaged in general practice at Affinity since 1920, but had been in semi-retirement for the past three years.

He served for several years as a member of the Raleigh County Board of Education, and served a term as its president. He was always interested in the civic affairs of the community.

He had been a member of the Raleigh County Medical Society, the West Virginia State Medical Association and the American Medical Association since 1921, and was elected to honorary lifetime membership in 1947.

Besides his widow, he is survived by a daughter, Mrs. Patricia Roberts of Winston-Salem, North Carolina; and a son, Dr. Michael J. Moore of Roanoke, Virginia. His survivors also include three sisters, two brothers, and five grandchildren.


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### Accidents: A Family Problem

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Burn deaths occur in the younger and older age groups. Suffocation in the home occurs principally in infants. Poisonings are particularly high in younger children and so are of great interest to the pediatrician and the general practitioner. Home accidents thus become generally a problem for the younger age group and the older age group, while motor vehicle accidents are predominantly heavy in the adult age group.

Accidents as a whole are primarily a family problem. They cut across the entire family from the youngest child to grandmother and grandfather. Since they are a family problem, the practicing physician, the public health worker, and others who have contact and work with the families of this nation should concern themselves with the solution to their problem.—Henry C. Steed, Jr. M.P.H., in Journal, Florida Medical Association.

You cannot run away from a weakness; you must some time fight it out or perish; and if that be so, why not now, and where you stand?—Robert Louis Stevenson.

# County Societies

### CABELL

The regular monthly dinner meeting of the Cabell County Medical Society was held in the Georgian Terrace Room of the Hotel Frederick on June 9, 1960.

The guest speaker, Dr. Bernard P. McNamara, Chief of the Toxicology Division, Army Medical Center, Edgewood Arsenal, Maryland, presented an interesting and informative discussion concerning the medical aspects of chemical warfare. He discussed particularly nerve gases, mustard gas, Phosgene, riot control agents, and the newer agents. The speaker emphasized the fact that the federal government is interested in developing agents which will temporarily incapacitate but not kill potential victims.

The speaking program was sponsored by Pfizer Laboratories.

At the business meeting preceding the scientific program, the folowing delegates were elected to the State Medical Association's House of Delegates: Drs. R. M. Bobbitt, W. E. Bray, J. G. Eder, and Walter C. Swann.

Alternate delegates were named as follows: Drs. George M. Lyon, J. M. Carter, W. E. Vest and Roy Edwards.

The following hold-over delegates and alternates will serve during the 93rd Annual Meeting of the West Virginia State Medical Association at White Sulphur Springs, August 25-27:

Delegates, A. C. Esposito, John F. Morris, R. J. Stevens, and Jack Leckie. Alternates, John E. Stone, Oscar B. Biern, H. E. Crews and Sara Louise Stevens.

The president, Dr. I. E. Taylor, presided at the meeting, which was attended by more than 150 members and guests. During the dinner hour, Dr. Thomas G. Folsom awarded prizes to the winners of the golf tournament held during the afternoon.—W. L. Neal, M. D., Secretary.

* * * *

### FAYETTE

The regular monthly meeting of the Fayette County Medical Society was held at the White Oak Country Club in Oak Hill on June 8. The affair was attended by members of the Society and Auxiliary, their children, and guests. There was a golf tournament in the afternoon and swimming in the Club's pool. Dr. Charles E. Watkins won the golf tournament and Drs. J. B. Thompson and W. P. Bittinger tied for second place.—Thomas C. Sims, M. D., President.

* * * *

### RALEIGH

Dr. Brian Blades of Washington, D. C., Professor and Head of the Department of Surgery at George Washington University, was the guest speaker at the regular


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monthly meeting of the Raleigh County Medical Society held on June 16 at the El Chico Cafe in Beckley.

The speaker discussed the surgical treatment of carcinoma of the lung and the technique and effects of perfusing human lungs with alkylating agents. This is a form of therapy which he is currently testing in cases of primary and metastatic carcinoma.

Dr. F. Vivan Lilly, the president, presided at the meeting which was attended by 58 members and guests. —Preston C. Davis, M. D., Secretary.

* * * *

### CENTRAL WEST VIRGINIA

Dr. Hunter Boggs of Charleston was the guest speaker at a meeting of the Central West Virginia Medical Society which was held at the Marlwood Inn in Richwood on June 30.

Doctor Boggs, whose specialty is dermatology, discussed many common skin allergies and their present-day treatment. He supplemented his discussion with slides.

Dr. John E. Echols, the president, presided at the meeting which was preceded by an open house at the home of Dr. and Mrs. James E. McClung.

The Society voted to participate in the Cancer Detection Program sponsored by the Cancer Committee of the State Medical Association and the West Virginia Division, American Cancer Society.

Dr. H. Summers Harrison of Summersville was elected a member of the Society.

Dr. James R. Glasscock was in charge of arrangements for the meeting and he was assisted by Drs. John E. Echols, Edward H. Hunter and James E. McClung.—Emma Jane Freeman, M. D., Secretary.

* * * *

### WYOMING

A joint meeting of the Wyoming County Medical Society and Auxiliary was held at the Cow Shed in Pineville on June 12, at which time delegates to the State Medical Association's Annual Meeting at White Sulphur Springs in August were elected. The delegates are Drs. Ross E. Newman and B. W. Steele, and the alternates, Drs. E. M. Wilkinson and R. C. Hatfield.

Dr. B. W. Steel and Dr. Florien Vaughn were elected to honorary membership in the Society.

An interesting film on the subject of "Respiratory Acidosis" was shown following the business session.—Ross E. Newman, M. D., Secretary.

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The idea that aged patients once admitted to a mental hospital must die there has been discredited. Many older patients have transient psychoses, such as depression, which yield to treatment, both physical and psychological. Many of them require brief periods of hospitalization and then can go back to their own homes, or to nursing homes.—Robert T. Hewitt, M. D., in Public Health Reports.


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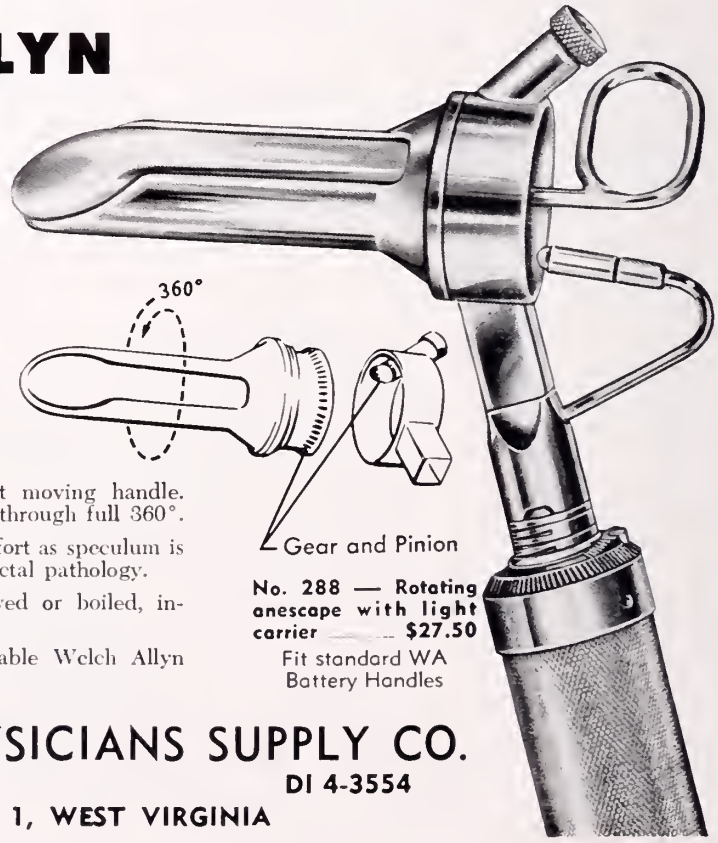


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# Book Reviews

**FUNDAMENTALS OF CLINICAL HEMATOLOGY—By Byrd S. Leavell, M. D., Professor of Internal Medicine, Physician in Charge, Hematology Section, University of Virginia School of Medicine, and Attending Physician at University of Virginia Hospital; and Oscar A. Thorup, Jr., M. D., Associate Professor of Internal Medicine, University of Virginia School of Medicine, and Attending Physician at the University of Virginia Hospital. Pp. 503, with illustrations. Philadelphia & London: W. B. Saunders Company. 1960. Price $10.**

This delightful text which comes out of Charlottesville, Virginia, is designed for the student who is being introduced to hematology for the first time. It is a comprehensive, but not encyclopedic presentation, quite adequate for practicing physician and student alike. The entire subject is covered in 429 pages plus two chapters dealing with techniques. The authors have not allowed important concepts to suffer from brevity. The reviewer and his associates have found this text to be very useful in instructing medical as well as medical technology students.

Practitioners who have referred hematological problems to Drs. Leavell and Thorup will be especially interested in this presentation.—John B. Harley, M. D.

## Books Received

**CURRENT SURGICAL MANAGEMENT II**—By Editors John H. Mulholland, M. D., Editor-in-Chief, New York University College of Medicine; Edwin H. Ellison, M. D., Marquette University School of Medicine; and Stanley R. Friesen, M. D., University of Kansas Medical Center. Contributions by fifty authorities. Pp. 348, with illustrations. Philadelphia and London: W. B. Saunders Company. 1960. Price $8.00.

* * * *

**THE LIST METHOD OF PSYCHOTHERAPY**—By Elizabeth Sher, et al, with an introduction by Jacob S. List. Pp. 258. Philosophical Library, 15 E. 40th Street, New York City. 1960. Price $7.50.

* * * *

**THE OFFICE ASSISTANT IN MEDICAL PRACTICE**—By Portia M. Frederick, Instructor, Medical Office Assisting, Long Beach City College, and Carol Towner, Director, Special Services, Communications Division, American Medical Association, with a foreword by George F. Lull, M. D., former secretary and general manager, American Medical Association. Pp. 407 with illustrations. Second Edition. Philadelphia and London, W. B. Saunders Company. 1960. Price $5.25.

* * * *

**MEDICAL RESEARCH AND THE DEATH PENALTY**—By Jack Kevorkian, M. D., Pp. 75. Vantage Press, Inc., 120 West 31st Street, New York 1, N. Y. 1960. Price $2.50.

* * * *

**MEDICINE TODAY**—By Marguerite Clark, Medical Editor of Newsweek. Pp. 360. Funk and Wagnalls Company, New York City. 1960. Price $4.95.

* * * *

**OFFICE DIAGNOSIS**—By Paul Williamson, M. D. Pp. 470, with illustrations. Philadelphia and London: W. B. Saunders Company. 1960. Price $12.50.

* * * *

**DISEASES OF THE NEWBORN**—By Alex J. Schaffer, M. D., Associate Professor of Pediatrics, The Johns Hopkins Medical School, Baltimore, with a Section on Neonatal Cardiology by Milton Markowitz, M. D., Assistant Professor of Pediatrics at Johns Hopkins. Pp. 878, with numerous illustrations. Philadelphia & London: W. B. Saunders Company. 1960. Price $20.00.

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# Correspondence

HILLCREST INCORPORATED
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Charleston 1, W. Va.

July 8, 1960

Mr. Charles Lively, Executive Secretary
West Virginia State Medical Association
Box 1031
Charleston 24, W. Va.

Dear Mr. Lively:

As I travel about West Virginia I find there is little realization that Hillcrest is available for emotionally disturbed children in the state and that there is considerable lack of knowledge of what is undertaken here. If you feel that this brief resume of its activities would be of interest to the members of the State Medical Association, I hope that you may find space for it in *The Journal.*

Hillcrest is celebrating its fiftieth anniversary as an institution for children. Founded in 1910 for tubercular children, it filled a great need until as a result of new drugs and treatment the number of children requiring its care diminished. Its Board of Directors still desiring to serve children then consulted social and medical organizations in the state, and following a survey of needs made by the Kanawha Welfare Council, and on its recommendation, prepared to join the pioneer groups working with emotionally disturbed children.

Hillcrest, Inc., began its new chapter as a residential treatment center, duly licensed in November, 1958, by the West Virginia Department of Welfare and the Department of Health.

The children for whom we could do the best work are between the ages of 6 and 12, not mentally defective, although frequently academically retarded because of handicaps like speech defects, or anxieties which interfere with their ability to concentrate in school or to make good adjustments at home or in the community. Many children considered mentally deficient have the potential to make readjustments and return to normal settings if they can have trained help at the proper time. Early recognition and referral is essential.

There must be understanding of the forces at work. Therefore, we must have professionally trained people. The clinical staff as constituted at present is as follows:

1. A psychiatrist, constantly in touch with other staff members to assist in diagnosis, to outline treatment and to evaluate progress.
2. A clinical psychologist who evaluates the intellectual and emotional potential of each child and points out the areas needing special treatment and training. He works closely with the teachers and cottage supervisors. He also sees the children in therapy sessions.
3. A registered social worker with services so diversified that they are difficult to describe. He

also observes the children in therapy sessions and supervises cottage care. Much of the material about a child being considered for admission is obtained and evaluated by this worker. Contacts with a child's family and with the referring agencies are in his field, and he helps plan for the return of the child to the community.

4. A resident nurse available for health supervision. Special nursing is obtained when children are ill. She also helps to supervise the food service, takes children for dental appointments and special examinations and assists in innumerable ways.

5. Two teachers, one full time, the other giving two hours a day, supplied by the Kanawha County Board of Education. Hillcrest could not operate without them in its task of continuing education for the children, giving help in their weak subjects and working closely with the psychologist so that the child can use the abilities he has, and to prepare him to return to a normal school setting.

6. Medical and pediatric consultation, and emergency room and surgical services are available through members of the Staff of Charleston Memorial Hospital.

7. A chaplain, recently added to the courtesy staff, has already enriched the program and has given impetus to our endowment project.

8. A cook enhances morale by her culinary skills and, in her contacts with the children as they help with the chores, adds to their education, growth and security.

9. Two maintenance men play their part in building a therapeutic atmosphere by providing guidance in carpentry and care of the grounds.

10. A secretary-bookkeeper, most essential in our efficient operation, helps to keep the entire program within the prescribed budget and funds available.

11. Five cottage supervisors provide constant companionship, family atmosphere at meals, at bedtime and at play.

I mention the supervisors last so as to have the opportunity to pay tribute to their devotion. It is in the cottages and in the periods of free activity that the children must acquire the skills of living in a world with other people. The supervisors have all the problems to meet that are known to any parent of several children, heightened by the quick tempers, oversensitivity, bad language and sometimes violent behavior which have been the defenses used by the children against what is to them a hostile world.

The problem of maintaining discipline, teaching responsibility, showing interest and affection, yet providing channels to drain off angers, fears and frustrations has no clear-cut blueprint but requires constant sensitivity to the needs of the child. The problem is complicated by the reaction of the group and the effort to make each incident a step forward in attaining maturity and self-sufficiency.

We have facilities to care for twenty children, evenly divided between the sexes. To evaluate a child for admission, it is essential that we have

(a) A social history, describing the child in his setting and indicating strengths and weaknesses in his family situation.

(b) A medical history, with report of recent examination, including chest x-ray and serology,


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and reports of inoculations. If the child has been hospitalized a note on his reaction to it would be helpful.

(c) Reports of psychometric and projective testing to aid in evaluating the child's ability to utilize residential treatment.

(d) An indication that the parents or referring agency will take financial responsibility.

(e) A visit by the parents or guardian, with the child, previous to decision either on their part or ours as to the advisability of admission.

It is the aim of the staff to help the children to develop more successful reactions to themselves and others, and to prepare them to return to home and school settings where they may continue to have understanding and support from their family physicians and community organizations.

We plan to have a modest exhibit at the Annual Meeting of the State Medical Association at The Greenbrier in August. We will be glad to answer questions or discuss cases with individual physicians at that time. Dr. Leon A. Dickerson, the president, Dr. Leo J. Mynes, board member, and Dr. Henrietta Marquis, pediatrician, and I will be available.

Treating children early should provide not only therapy for the existing condition, but also a measure of emotional stability with which to meet future stresses.

Sincerely yours,

(Signed) Margaret T. Ross, M.D.,
*Director.*

MTR/mc

## What's Happened to Old Jim?

We're asking you—not telling you.

We have learned that the *Pennsylvania Medical Journal* has a sizable body of readers who attack our publication by leafing rapidly toward the back to see who among their classmates, acquaintances, or friends have "made" our pages of news. They are apprehensive about it, since their first stop is at the obituary pages. But, once this hurdle is left behind, they have more pleasure. They are looking for familiar names in our list of marriages, births, and notices of achievements in academic, professional, or medico-political spheres.

This is a concern of ours which we wish to share with you, dear reader, because we realize that we are not getting more than a fraction of the news which would be of interest to our readers.

We have determined to revamp the old system of having reporters in each county medical society. We are also going to enlist the help of the Woman's Auxiliary in trying to get the "dope" on our fellow physicians. But, in the long run, it all depends on you.

So, go on out and make some news—get elected senator or find a cure for kala-azar or something. Or, in case this doesn't pan out, let the *Journal* know by card or letter or via your county society of any news of your fellow physicians which we ought to print.—The Pennsylvania Medical Journal.


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## The Cost of Medical Care

The American nation spends more for liquor, tobacco, cosmetics, beauty treatments, movies, television and baseball games than it does for medical care. Yet medical care seems to be the prime target for every social planner. It should be provided "for nothing," apparently for not better reason than that it is something needed. One should not be required to waste money on a genuine need. "The Government," the father of all, should provide this. The citizen should spend the "allowance" it gives him only on his pleasures

To be sure, doctors have a good deal to lose if this should happen, but patients, even though they may presently be unaware of it, have as much or more to lose in the long run. It is the duty of doctors on behalf of their patients, as well as in their own interest, to learn all they can about voluntary medical-care insurance. Far from being the meddlesome "third party" for which they have an uneasy fear, it stands with them in the common effort to preserve a cherished concept of freedom. It enables each man to make provision for his medical care out of his own resources as an independent and free citizen. It helps him to afford the best available medical care, even though that is necessarily expensive.—C. Marshall Lee, Jr., M. D., in The New England Journal of Medicine.

## A Common Effort Needed

A common effort on the part of the insurance interests and the medical profession will be necessary if medical care is to be kept in the hands of those who deliver it and those who receive it, and out of the hands of their increasingly paternalistic government. Time has been lost in developing the necessary art of pulling together instead of working at cross-purposes and it may be too late to preserve a free system, but it is not too late to make the effort. Such an effort can be effective, however, only if each understands the functions of the other and petty jealousies and major self-interests are sublimated.—The New England Journal of Medicine.


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**Pediatrics:** CORA C. LENOX, M. D.

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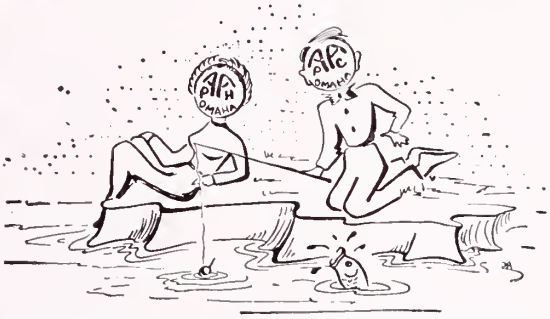

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## Factors in Accident Occurrence

The dictionary definition of the word accident is a poor one for describing what happens in an accident situation. It tends to leave the impression that accidents are inevitable and that there is not much that can be done to prevent them. It further gives the impression that an accident is a sudden occurrence and an unforeseen happening. Neither is true because accidents are often slow in onset and usually are foreseeable, even predictable. If a person is able to recognize and be aware of the factors leading to an accidental occurrence, he stands an excellent chance of preventing it.

There are several factors involved in an accidental occurrence. This view leads to a concept differing from that previously accepted in that a home accident should be viewed in terms of a sequence of events leading up to a measurable or recognizable result, such as injury, death, or property damage.

With this concept it is easy to recognize that there are many factors behind an accidental occurrence and that accidents are not something that "just happen." If the physician is aware of this basic factor lying behind the accidental occurrence, he will be able to evaluate and do a more effective job in preventing this occurrence. Just as in disease, there are causes for all accidents; therefore, they can be prevented.

There are two major aspects of accidental occurrences found in all of the factors of the accident sequence. These are environmental aspects and human aspects. Accidental occurrences always involve one or both of these aspects, usually both.

The environmental aspects include the many adverse conditions introduced through the environment of man, such as the home itself. Poor construction, slippery floors, loose stair treads, poor storage of poisons and medications—all are environmental aspects where control measures can be practiced. The human factor is the least tangible and the most difficult to recognize and to measure. It involves human behavior and the change of such behavior to prevent accidents. It also involves such things as crippling conditions, haste, fatigue, and the most intangible of all, poor judgment.

These aspects and factors of accident occurence are all directly related to the family and the home in which the family lives. Each and every person must accept accident prevention as a way of life, just as he has accepted the brushing of the teeth and the washing of the hands as a personal hygiene way of life. The practicing physician can contribute greatly to the solution of this most complex problem of accidents.—Henry C. Steed, Jr., M. P. H., in Journal, Florida Medical Association.

## Books

Of the many things man can do or make here below, by far the most momentous, wonderful and worthy are the things called books.—Thomas Carlyle.

## Home Social Guidance

A Boston University child psychiatrist is sending trained social workers into the homes of emotionally disturbed children in crisis cases. These children need immediate care but the long waiting list at the guidance clinic prevents early treatment.

Many of the more seriously ill youngsters had been hospitalized for two or three weeks, diagnosed as not psychotic, and sent back to a home where they again face the same problem. The clinic worker now goes to the patient's home and attempts to relieve the crisis responsible for the bizarre behavior of the child. Hospitalization is averted and family equilibrium reestablished. On the other hand, when hospitalization is needed the family is in a better position to cooperate.—Illinois Medical Journal.

Peter P. Ladewig, M. D. Willis D. Garrard, M. D.

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## The Genesis of Field Medicine Organization

In the beginning of the Civil War the United States Army had no ambulance service, no field hospital system. There were 2 ambulances per regiment and these belonged to the Quartermaster.

The first field hospitals were organized by Surgeon H. S. Hewitt, U. S. Volunteers, at Fort Donaldson in February 1862, the "medical director" of General Grant's Army of "green volunteers." For the campaign he collected all the regimental hospitals and ordered 4 field hospitals for the 28 regiments. Three hospitals were in local buildings; the fourth was in tents—the first tent field hospital of the war.

Surgeon Hewitt, judged by his full scholarly and instructive reports, was an educated man and a close observer and a logical reasoner, resourceful and energetic. He was doubtless informed as to ambulance trains and field hospitals in other countries. He was organizing them when Surgeon Tripler of the Regular Corps was clinging to regimental hospitals and rejecting ambulance corps.

In the fall of 1862 the Surgeon General William A. Hammond recommended a pavilion type field hospital to Jonathan Letterman, Medical Director of the Army of the Potomac. All who served in World Wars I and II are familiar with the pavilion type tents of the field and evacuation hospitals.

In July 1862 Surgeon Tripler was succeeded as Medical Director of the Army of the Potomac by Surgeon Jonathan Letterman. At that time the ineffectives amounted to 20 per cent, the death rate was 50 per thousand. The reasons for this sad state of affairs according to Tripler were: (1) Not enough medical officers; (2) Denial of rank and official position; (3) The idea that surgeons were "merely doctors" to be called on to treat the sick but not to institute sanitary measures; (4) Not having control of transportation; and (5) Professional incompetency of some officers.

Letterman, cognizant of Larrey's work, envisioned the whole problem of medical logistics in the field and promptly improved sanitation; instituted ambulances; ambulance companies; and field, evacuation, and general hospitals. Thus at the Battle of Antietam, for the first time in the war, all the wounded were hospitalized on the day of battle.

In transport to general hospitals freight cars and wagon train had formerly been used. During the ensuing year Surgeon General Hammond instituted hospital trains for transport from railheads back to general hospitals. Thus in an extraordinarily short period the genesis of the proper organization of field medicine was conceived.—Frank E. Berry, M. D., in Armed Forces Medical Journal.

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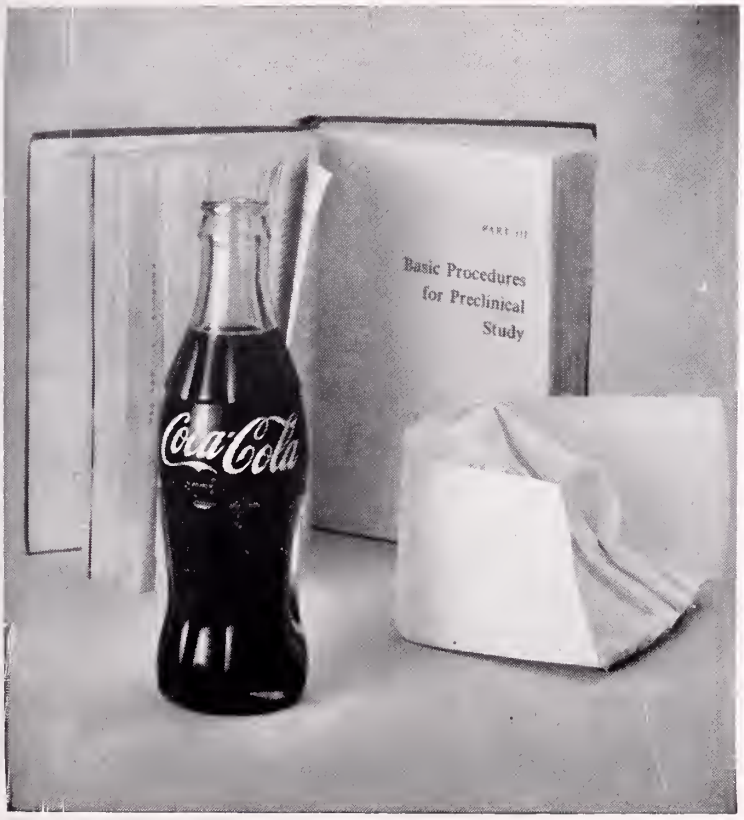
"Stop waving your arms and making faces, sir," said the dentist impatiently. "I haven't even touched your tooth."

"But, doctor," wailed the patient, "you're standing on my corn."—Medicovan.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## A New Goat

The recent shellacking the drug industry received from a congressional committee made satisfying reading. The news stories were sensational and exciting, and seemed to buttress the opinions many had entertained for years.

But like many another free-wheeling congressional investigation, the damage done was far in excess of the good the investigation accomplished. In this case, the sin was one of omission.

While the headlines screamed about huge profits—the highest rate in the United States—garnered by the drug industry, there was practically no mention of the fact that many modern drugs were developed from research paid for by a large part of those profits. The entire area of cooperation between academic scientists and commercial houses was ignored. Yet, it was this cooperation that produced drugs making possible fantastic progress in the treatment of tuberculosis, mental illness, diabetes, and many other diseases, as well as major advances in fundamental science. In fact, few important drug developments in recent years have been made outside this sphere.

Little was written about the $20 million that the drug industry contributed to medical schools, hospitals, and research institutions in the year 1958. With the help of this support, medical scientists have found means to make productive millions of man-hours that would otherwise have been rendered barren by sickness. Obviously this money must come from somewhere, and it is a sign of enlightened self-interest on the part of drug company management that it comes from private industry as well as from tax supported agencies.

"Big Business" is always fair game for sensation hunters in the Congress and in the Fourth Estate. The drug industry is especially susceptible to blast because nobody voluntarily buys a prescription and some resentment may be felt about its necessity. Admittedly, there are practices in the drug industry which are hard to explain—some periodic public exposition is unquestionably good for the corporate soul.

But since the virtues of the drug manufacturers are not the concern of Congress, they should be enumerated somewhere along with their sins. The public should be aware that not all the prescribed "loot" is pocketed by greedy management. It may make dull reading in comparison to the disclosure of profit-taking; but when the full story is told, the drug industry can be proud of its significant contribution to our health and well-being.—David N. Goldstein, M. D., in Current Medical Digest.

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A man who hadn't seen an acquaintance for a couple of years told him there was something different about his appearance, and the acquaintance revealed, "Yes, I've had my wrinkles tightened up by plastic surgery."

"Makes you look younger," said the friend.

"Not only that," came the reply, "it prevents backache."

"How's that?"

"It's like this: when I need to pull up my socks, I just lift my eyebrows."—Anon.


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## Danger in a Kiss

Very many of the diseases to which we poor mortals are liable can be prevented, provided proper efforts are put forth to meet that most desirable end.

This truth no one will gainsay, still, the subject has not yet attracted the attention its importance demands, and it appears now to be the especial duty and province of those of our profession who live in this day of preventive medicine to erect finger boards along the highways of life, which shall point out clearly and plainly the known causes of disease. . . .

There is oftentimes danger in a kiss, notwithstanding Lord Byron, that prince of poets, in the days gone by expressed the wish

"That womankind had but one rosy mouth,
To kiss them all at once from North to South."

Ah! it was a bad wish even for so bad a man, and so faithless a lover as he, yet it does seem that he was not peculiar in this respect, since in this glorious age of enlightened progress, such sickly sentimentality is no less popular, and has no fewer votaries than in the days of old, because kissing, kissing, kissing is still the order of the day.

The ladies kiss each other upon every offered opportunity, every flimsy pretext; the poor little children, and even the babies are made to do likewise in compliance with the requirements of genteel society, and the men too, would do the absurd thing at every meeting were it not for the lamentable truth that they are obdurate and have not yet been educated up to the sound, civilized and philanthropic principle of "dog eat dog."—R. L. Payne as quoted in New Orleans M. & S. J., January, 1880, and reprinted in Journal, Louisiana St. Med. Society.

## Strontium 90

The fear that fallout of Strontium 90 from nuclear explosions may become a hazard to health stems as much from ignorance as it does from knowledge of the effects of radiation on biologic processes. The degree of present upper-air contamination, the rate of settling and the distribution in plants and animals are all matters of conjecture rather than matters of fact. Man has been exposed for eons to significant sources of radiation from cosmic rays without and from radioactive elements within. It is quite likely that exposure to radiation from man-made sources will never exceed that from nature. In any case, the essence of the argument over Sr 90 is not one of magnitude but that it represents a source of radioactivity over which there should be control.

A recent news release by the New York City Department of Health amply summarizes the known facts and points to the sources of ignorance. It concludes that the concentrations of Sr 90 now found in milk and other foods have not been shown to be harmful to human beings. Some success is reported with chemical means of removing this troublesome element from milk, but such removal has been carried out only in pilot, laboratory studies and is not yet adaptable to commercial milk production. It has also been suggested that osseous Sr 90 deposition could be prevented by "flushing" with excess calcium added to the diet. However, this measure in itself would carry with it some risk.

The report ends on the chief source of man-made ionizing radiation and is a reminder that the diagnostic and therapeutic use of x-rays should remain under careful surveillance lest this become a serious risk to health.—New England Journal of Medicine.

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It is not who is right, but what is right, that is of importance.—Thomas Huxley.

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*Dosage:* Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

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*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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*Many of you may have seen a recent cartoon depicting a midnight scene in front of a pharmacy. A woman is pounding on the door and the pharmacist is leaning out the window of his apartment over the store. "Open up," shouts the woman. "My husband is sick and I need a stamp so I can send this prescription to the mail order house."*

# The drug that always fails is the drug that isn't there

Far-fetched? Perhaps, but there are those who would have us believe that our present system of drug distribution is inefficient and costly, and should be replaced by presumably more efficient and cheaper centralized or bureaucratic methods. Disregarding the probable political philosophy behind these suggestions, consider what a marvelously intricate and efficient system of drug distribution we have in this country. • From the laboratories of the manufacturers comes a steady stream of new and better drugs for your patients. Warehoused and stocked by drug wholesalers, these products are available in over 53,000 pharmacies scattered across the length and breadth of our land. And woe to the pharmacist who hasn't been provided with yesterday's laboratory discovery for your use in treating a patient today. • The economists speak of "utility of time" and "utility of place." We simply say that you can confidently prescribe *what* you choose, *when* it is needed, *wherever* your patient may be.

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## The Old Order Changeth

We doctors are presently in the public's doghouse. Our public relations seem to be at an all time low. We seem to have become the whipping boy for our present day society. A whipping boy, in case you don't remember, is "a boy educated together with a royal personage, and flogged in his stead when he commits a fault that was considered to deserve flogging." In this election year we may expect to feel the rod more often.

We all know the almost unbelievable advances made in all fields of medicine in the past fifty years. Largely because of this progress more people are now well-born, or born well, and live healthier and happier lives. At least, they live healthier lives than formerly, and they live longer. There are going to be more and more old people around. (I don't know how you define old people. Most people consider "old" anyone who is ten years older than himself.)

These old people will continue the habits formed earlier. That is, they will continue to eat two or three meals a day, wear clothes, and live in houses which they rent or own. They will also occasionally have some illness, physical or mental. And sooner or later each will have a terminal illness of longer or shorter duration. "As sure as death and taxes" expressed this certainty.

The taxes people seem to accept as necessities and somehow are prepared to pay them. Living expenses are taken for granted, too, but not doctors' bills. At least our legislators and political candidates do not make the welkin ring with appeals to the electorate to buy grandpa a pair of new shoes or give him free groceries. Nor have I heard suggestions that the shoe dealer or grocer supply them free or for less than cost. This may come, but for the present free medical care (free, except that we all pay for it in a more expensive and roundabout way) whether there is a proven need for it or not, is the panacea, the cure-all, offered for all the problems of the older citizen and voter.—Alfred L. Potter, M. D., in The Rhode Island Medical Journal.

## Rehabilitation Defined

Rehabilitation has been defined as the ultimate restoration to the disabled person of his maximum capacity —physical, emotional, social and vocational. Implicit in this definition is the need for a team whose members can bring together a wide variety of skills and understandings. No one profession can furnish all the services needed. Rehabilitation is, rather, an area of specialized activity within a number of professional disciplines.—Howard A. Rusk, M. D., in Rhode Island Medical Journal.

### Need a New Auto Emblem?

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

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| Boone | James M. Scott | Madison | H. H. Howell | Madison | 2nd Wed. |
| Brooke | James E. Wise | Follansbee | H. L. Hegner | Wellsburg | |
| Cabell | I. Ewen Taylor | Huntington | W. L. Neal | Huntington | 2nd Thurs. |
| Central West Virginia | John E. Echols | Richwood | Jane Freeman | Buckhannon | As Scheduled |
| Eastern Panhandle | George F. Pugh | Martinsburg | F. A. Hamilton, Jr. | Martinsburg | Quarterly |
| Fayette | Thomas C. Sims | Longacre | Marvin Kirsh | Montgomery | 1st Wed. |
| Greenbrier Valley | E. T. Cobb | Ronceverte | James Hamilton | Marlinton | 2nd Wed. |
| Hancock | George Naymick | Weirton | Arthur Phillips | Weirton | 2nd Tues |
| Harrison | Richard V. Lynch, Jr. | Clarksburg | Andrew J. Weaver | Clarksburg | 1st Thurs. |
| Kanawha | Milton J. Lilly | Charleston | A. B. Curry Ellison | Charleston | 2nd Tues. |
| Logan | Ray M. Kessel | Logan | Luke Combs | Man | 2nd Wed. |
| Marion | S. L. Stillings | Mannington | G. Thomas Evans | Fairmont | Last Tues. |
| Marshall | H. B. Ashworth | Moundsville | J. W. Myers | Moundsville | Semi-Ann. |
| Mason | C. Leonard Brown | Pt. Pleasant | Dan Glassman | Pt. Pleasant | |
| McDowell | Guy E. Irvin | Welch | George L. Fischer | Welch | 2nd Wed. |
| Mercer | W. E. Copenhaver | Bluefield | John J. Mahood | Bluefield | 3rd Mon. |
| Mingo | Frank J. Burian | Williamson | Russell A. Salton | Williamson | 2nd Thurs. |
| Monongalia | David Z. Morgan | Morgantown | C. A. Logue | Morgantown | 1st Tues. |
| Ohio | S. S. Babes | Wheeling | H. G. Dickie | Wheeling | 4th Tues. |
| Parkersburg Academy | Jack J. Stark | Belpre, Ohio | Robert M. Biddle | Parkersburg | 1st Thurs. |
| Potomac Valley | P. R. Wilson | Piedmont | H. L. Eye | Franklin | 2nd Wed. |
| Preston | John F. Lehman | Kingwood | C. Y. Moser | Kingwood | 4th Thurs. |
| Raleigh | F. Vivian Lilly | Beckley | Preston C. Davis | Beckley | 3rd Thurs. |
| Summers | Jack D. Woodrum | Hinton | A. W. Holmes | Hinton | 3rd Wed. |
| Taylor | R. D. Stout | Grafton | Herbert N. Shones | Grafton | Last Thurs. |
| Wetzel | Lemayne Caffield | New Martinsville | C. P. Watson, Jr. | New Martinsville | Monthly |
| Wyoming | E. M. Wilkinson | Pineville | R. E. Newman | Mullens | Quarterly |

# The West Virginia Medical Journal

September, 1960 Vol. 56, No. 9

## Modern Concepts of Hemodynamic Effects Of Aortic Insufficiency*

*Carl J. Wiggers, M. D.*

It is a privilege to participate in a scientific program dedicated to a valued friend and respected colleague, Edward J. Van Liere. His career has exemplified the demanding standards a scholar sets for himself; his contributions to physiology and experimental medicine have added greatly to our knowledge; and his services as Dean have set a fine example of devotion to the cause of better medical education and of loyalty to a single institution. I am sure that the Medical School of West Virginia University feels that, in honoring him, it is no less honoring itself.

As an emeritus professor, no longer privileged to work in an experimental laboratory, I am deeply concerned lest I be unable to contribute as substantially to this colloquium as the occasion demands. Indeed, an emeritus professor is in the same predicament as a spouse who is required to prepare a palatable meal from leftovers. The embarassment is augmented when such a meal must be served to gourmets. My wife assures me, however, that a tempting meal can be concocted by selecting only the best remnants and by blending and seasoning them in a tasteful manner. It therefore seems a wise policy to present to this discriminating audience only selected hemodynamic aspects of semilunar valve insufficiency that have interested my associates and myself since 1914. I shall endeavor to spice my discourse by brief references to recent work which has reinforced, supplemented or invalidated opinions previously expressed.

### *Van Liere Number*

**The Publication Committee is proud to dedicate this issue of The West Virginia Medical Journal to one of its members, Edward J. Van Liere, M. D., who will soon retire as Dean of the West Virginia University School of Medicine following 25 years of outstanding service in that capacity.**

### *The Author*

• **Carl J. Wiggers, M. D., Professor Emeritus of Physiology, Western Reserve University School of Medicine, and Honorary Professor, Frank E. Bunts Educational Institute, affiliated with The Cleveland Clinic Foundation, Cleveland, Ohio.**

My personal interest in the dynamics of aortic insufficiency was aroused by a paper published in 1908 by Hugh Stewart,[1] one of the pioneer American clinical investigators. His untimely death robbed clinical research of a promising talent. Stewart called attention to the fact that collapse of the recorded radial pulse in patients with aortic incompetence occurs before the dicrotic wave, that is during systole; hence cannot be attributed to regurgitation of blood.

A review of the pertinent literature at that time indicated that many clinicians and investigators had already attempted to account for the circulatory changes ever since Corrigan[2] described the typical pulse that is still known by his name. I expect to deviate from the customary chronological survey of the literature which cites conclusions reached by each investigator at par value. Instead, I shall briefly survey some pathways for approaching the problem, examining as we proceed, the limitations of procedures and appliances used and the validity of inferences drawn from available data.

#### Logical Reasoning and Experimentation

No one who pauses to reflect can fail to admire the master minds of medicine who, through careful observation and logical reasoning, explained many of the established signs and symptoms of

disease. The list of clinical logicians includes Corrigan who attributed the sharp systolic impact of the pulse to the forceful ejection of a large pulse volume by a hypertrophied left ventricle into relatively empty arteries. He ascribed the sensation of a sudden collapse to the reflux of blood into the left ventricle. However, it was later noted that peripheral pulses of similar form also occur during extreme vasodilatation (amyl nitrite), in arteriovenous fistulas, and during arterial hemorrhage in all of which reduction of peripheral resistance is a common denominator. With the description of the capillary pulse by Quincke,[3] the suggestion that peripheral vasodilatation might play a dominant role in production of the Corrigan pulse gained momentum at various periods of the past half century.

It was precisely similar situations which allowed more than one interpretation of natural phenomena that impelled philosophers of old to seek more facts for reasoning through experimentation. In the present era of enthusiasm for experimentation, this prime purpose of experimental approach must be kept in mind; facts obtained by experimentation have little value unless correlated, and their proper interpretation is the chief aim of research. Unfortunately in science, as in theology and politics, quite different deductions can be made from the same body of facts. The difficulty of detecting flaws in reasoning has retarded acceptance of a common explanation in various domains of circulation research; it has recurrently swung fashions in thinking in opposite directions as more data became available through experimentation.

### The Evaluation of Experimental Data

Sound reasoning presupposes that data uncovered by experiments are authentic, complete, and applicable to the argument. Since hemodynamics is a physical problem, it would seem that information obtained from controllable mechanical models would be the most decisive.

*Mechanical Circulation Models.*—The use of circulation machines for elucidating circulatory dynamics was initiated by E. J. Marey, the great French instrumentalist and physiologist. Since the appearance of his monograph in 1863,[4] analogs of the circulation have been used extensively in physiology teaching to illustrate the determinants of arterial pressure and pulse forms. By means of such machines it can readily be shown that incompetence of the outlet valves produces a greater fall of diastolic than of systolic pressure, a larger pulse pressure and changes in the amplitude and catacrotic limb of arterial pulses that resemble the Corrigan pulse in patients (Figure 1). In suitable circulation models it can also be demonstrated that a constant venous stream changes to an intermittent one, thereby demonstrating that a capillary pulse can be produced without changing the peripheral resistance. Measurement of peripheral outflow reveals that the net stroke and minute volumes are reduced through reflux of blood during diastole.

It is questionable whether information so obtained can be transferred to hearts of animals and man for (a) the area of leak is often nearly

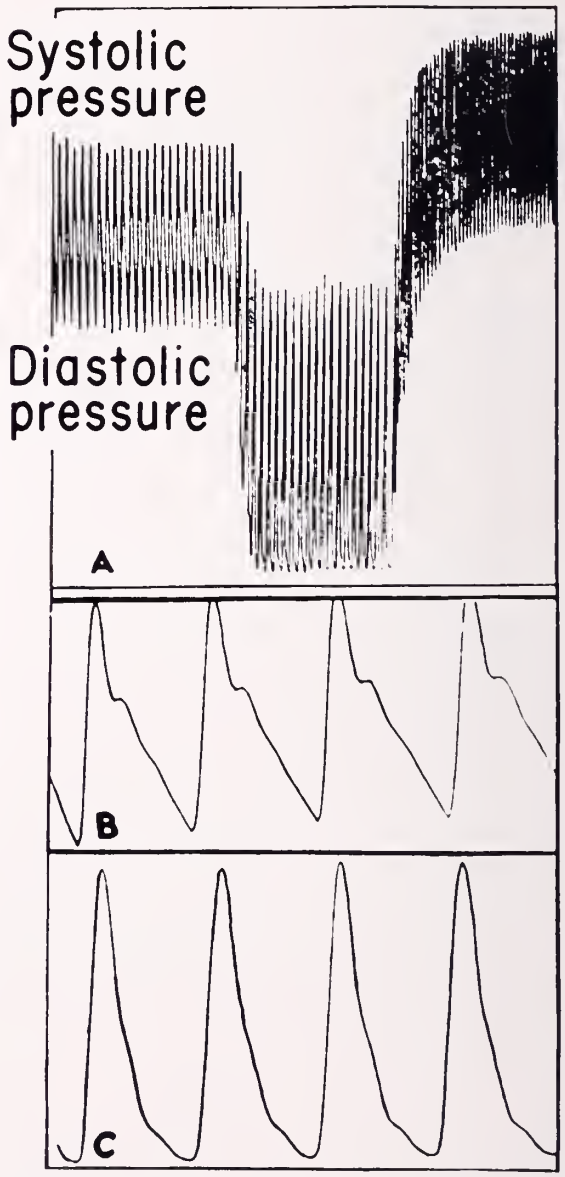


**Figure 1. Hemodynamic effects of aortic insufficiency produced in an artificial circulation machine. A, Effects of the lesion on systolic and diastolic pressure and compensatory effect of cardiac acceleration. B, pulse contour before. C, after induction of insufficiency.**

Presented in connection with a special program honoring Dr. Edward J. Van Liere, Dean, West Virginia University School of Medicine, which was held at the Medical Center in Morgantown on May 12.

the same as that for ejection, (b) pressure relations in a pump and an artificial aorta are quite different from those in the heart during ejection, and (c) the ventricular impedances to diastolic inflow from the atrium and aorta are difficult to duplicate in models.

*Simulation of Semilunar Valvular Incompetence in Animals.*—The great master of experimental physiology, Claude Bernard, taught that all diseases are experiments which nature performs, and that the most hopeful way of interpreting the signs and symptoms is to create similar disturbances in animals. Unfortunately human ingenuity in duplicating nature's experiments is somewhat restricted by the necessity for anesthesia and operative procedures which are apt to alter the conditions and reactions of animals. Also, the abrupt rupture of semilunar valves by an instrument throws an immediate rather than gradual burden on the heart. Furthermore, faulty instrumentation and technic have often given confusing, and even false, answers to questions under investigation.

The experimental approach to the dynamics of aortic insufficiency began in the latter quarter of the nineteenth century (for references see previous reviews).[5, 6] It was found that experimental destruction of the semilunar valves generally caused an immediate fall of mean arterial pressure, from which prompt recovery occurred in favorable experiments. This demonstrated a basic fact; hypertrophy is not the only compensatory mechanism. This was a forward step, but it failed to throw light on the magnitude of the regurgitating fraction or on the mechanism by which compensation takes place. However, then, as still happens too frequently, it was convenient to attribute any pressor or depressor alteration of mean blood pressure to changes in peripheral resistance.

In 1908 Stewart not only presented cogent arguments for the revolutionary view that the collapsing arterial pulse cannot be caused by regurgitation but is well explained by vasodilatation; he also supported the view by seemingly convincing experiments. He showed that irritation of the aortic root by a probe caused a fall in arterial pressure, conceivably by as yet unknown aortic baroreceptors. By inclosing the two ventricles in a cardiometer and registering changes in their volumes he found that their diastolic volume was not increased by creation of semilunar incompetence as would be expected from a significant backflow; on the contrary, the diastolic volume decreased. Since this occurred in experiments in which the heart rate remained unchanged, it was assumed that the ventricles responded with an increase in tonus, and that this was one mechanism that prevented significant regurgitation. A year later Zollinger reported that, in his experiments, the diastolic ventricular size increased but the stroke volume was unaltered. By subtracting the measured output in a heart-lung preparation from the gross output calculated from cardiometer tracings, Straub concluded in 1914 that 56 per cent of the stroke volume regurgitated during semilunar insufficiency (see references 5 and 6). Such contrary findings by competent investigators, presumably using the same methodology, can only mean that results depend largely on the condition of the animals after their chests are opened.

With the extension of roentgenographic technic to experimental laboratories, the effects of semilunar incompetence could be studied with less operative trauma to animals. However, reports again were contradictory. For instance, Eyster[7] found an immediate enlargement of the heart after experimental rupture of aortic valves, while Bazett and Sands[8] observed smaller heart shadows that could be explained partly, but not wholly, by an attendant cardiac acceleration. Such experiments demonstrate the necessity of somehow maintaining a constant heart rate in order to analyze the basic consequences of aortic incompetency. It should further have been apparent that it is almost impossible to infer what happens in the left ventricle from procedures that estimate changes in size of both ventricles.

The advantage of studying changes induced by aortic valve lesions in the pressure pulses of the left ventricle and aorta is apparent. It may be recalled that Chauveau and Marey working at Lyons, France, were pioneers in the performance of cardiac catheterization. They introduced catheters tipped with ovoid baloons into various vessels and cardiac chambers of unanesthetized horses and recorded pressure fluctuations with Marey tambours. In his classical monograph,[4] Marey stated that he and Chauveau had found an immediate typical change of the pulse in a facial artery after induction of semilunar insufficiency. He stressed that production of a typical Corrigan pulse does not depend on the development of left ventricular hypertrophy as was still commonly assumed. In Marey's own words, "it is a mechanical effect of aortic valve incompetence, itself." Unfortunately, their published ventricular pressure pulses were obviously distorted by technical artifacts and do not support their interpretations that regurgitation is of such magnitude that ventricular end-diastolic pressure almost equals that in the aorta. During the three decades following, intensive efforts were made to improve pressure recorders and technical pro-

cedures. However, manometers adequate for following intraventricular and aortic pressure fluctuations faithfully were not available until O. Frank constructed optically recording types on the basis of new mathematical principles.

### Personal Studies

In 1912 it was my privilege to serve an apprenticeship under O. Frank in Munich. I brought back with me his new optically recording manometer and soon set out to modify its design to suit different experimental purposes. Thus equipped, I undertook an investigation of the immediate effects produced by a sudden aortic insufficiency. I devised a special sound fitted with a plunger that could be thrust through the ventricular wall into the root of the aorta. Withdrawal of the plunger caused an immediate insufficiency, pushing it back abrogated the leak, each within a second or two. Ventricular and aortic pressure pulses such as are reproduced in Figure 2 permitted not only an analysis of immediate effects, but also allowed deductions regarding immediate compensatory mechanisms.

The left panel of this figure shows records of ventricular and aortic pressure pulses with the plunger in place. The ventricular curve has all the characteristics found in efficiently contracting ventricles. The curve may be divided into an isometric phase (A-B), an ejection phase (B-C) an isometric relaxation phase (C-D) and the remaining period of diastolic inflow (D-A). The right panel illustrates effects following the withdrawal of the plunger. We note the following changes in the ventricular pressure pulse: The pressure reaches a higher summit earlier in systole. The aortic pressure pulse shows corresponding changes in contour, but since they were recorded with a more sensitive manometer, the earlier systolic peak (4) and late systolic drop in pressure (4-5) appears more obvious. We later referred to this as the "systolic collapse." However, pressure declines most drastically after the incisura (5-6) i.e., during diastole. Since these changes took place immediately after withdrawal of the plunger, time for reflex vasodilatation such as Stewart postulated was out of the question. The large drop in diastolic pressure was obviously related to the leak, but whether the loss of pressure was accompanied by a significant reflux of blood could not be stated at the time. However, by 1923, I[9] ventured the opinion that, "experimental evidence contradicts the view so prevalently held that a large portion of the systolic discharge flows back in each subsequent diastole." The concept of regurgitation of pressure without transfer of liquid was illustrated by connecting two bottles completely filled with water but under different pressures; when a stopcock between the two connecting bottles was opened, pressures would equalize without transfer of liquid.

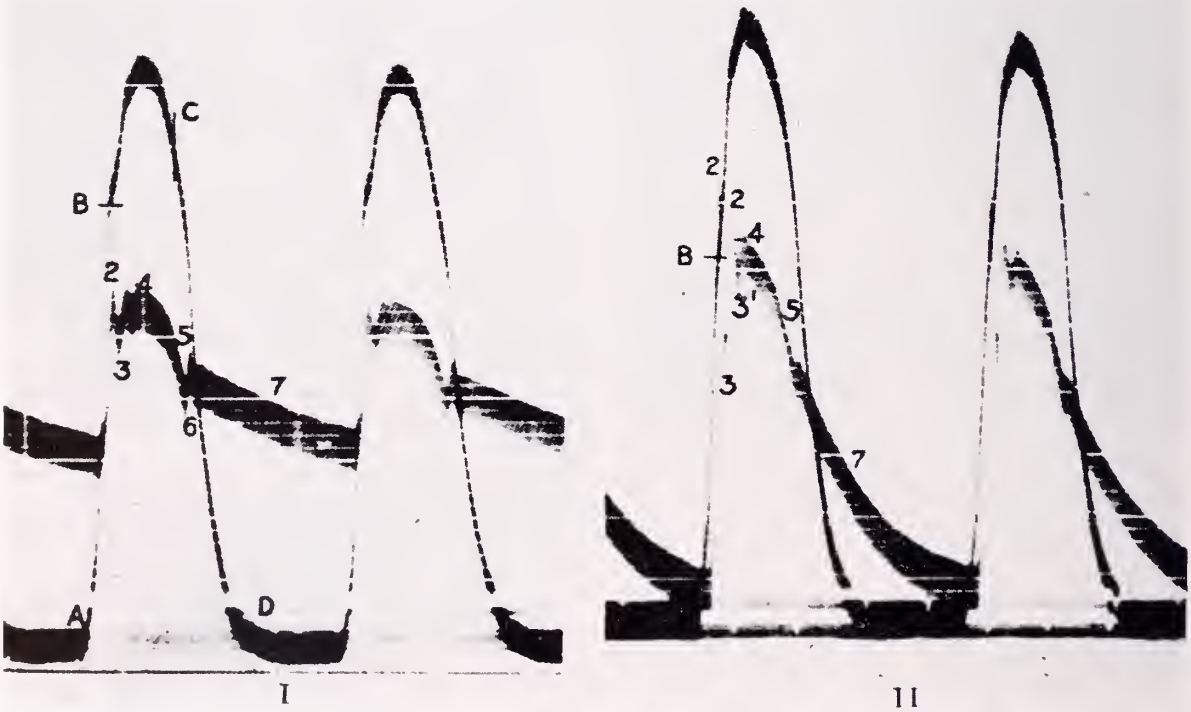


Figure 2. Subclavian and intraventricular pressure pulses recorded in 1914. I, Control. II, After experimental aortic insufficiency.

Time does not permit me to review the accumulating experimental evidence (1) that the impedance of the relaxed ventricle was insufficient to simulate such a mechanical arrangement and (2) that it was obviously necessary to abandon my earlier view. Such reveiws are available.[5,6,10] Because of its clinical possibilities, I may be permitted to restate a later opinion that the magnitude of reflux volume depends on the size of the semilunar orifice. In 1930 we produced leaks of different sizes by use of a valve spreader. We found that the changes in aortic and ventricular pressures previously described attended only mild degrees of valvular insufficiency. When the semilunar valves were spread wide apart the dynamic consequences were different. These differences are shown in Figure 3. Whereas in mild insufficiency (Panel B) aortic pressure declines chiefly after isometric relaxation of the left ventricle (F-I); in severe insufficiency (Panel D) it drops abruptly during isometric relaxation (F-I).

These temporal differences in the dominant degradation of aortic pressure depend on the mechanism of cardiac relaxation. At the end of systole (F) the ventricle normally reduces its tension for .06 to .08 sec. owing to the release of elastic forces stored during systole. During this phase of isometric relaxation (F-I) its cavity is not enlarged. The cavity can also not be significantly enlarged with mild degrees of valvular incompetence, because the orifice still offers considerable resistance against the high aortic pressure. When the aortic aperture is large, however, this resistance is lost and the high aortic pressure can enlarge the ventricular cavity forcefully by moving blood into it. There is another difference: During mild insufficiency of the aortic valves, any backflow after isometric relaxation must compete for ventricular space with blood entering from the atrium; in severe insufficiency, aortic backflow precedes filling from the atrium. According to recent studies of Warner and Toronto,[11] the initial velocity with which regurgitation takes place in severe aortic insufficiency may exceed 100 cm. per second.

These experimental studies led me to review some subclavian pulses that I had recorded from time to time from patients with established aortic insufficiency. The records could be grouped as Type I in which degradation of pressure occurs chiefly after the incisura and continues throughout diastole, and Type II in which it occurs dominantly during isometric relaxation (Figure 4). The deduction seems fair that patients exhibiting central arterial pulses of Type I have mild degrees of aortic insufficiency; those with pulses of Type II are afflicted with large leaks.

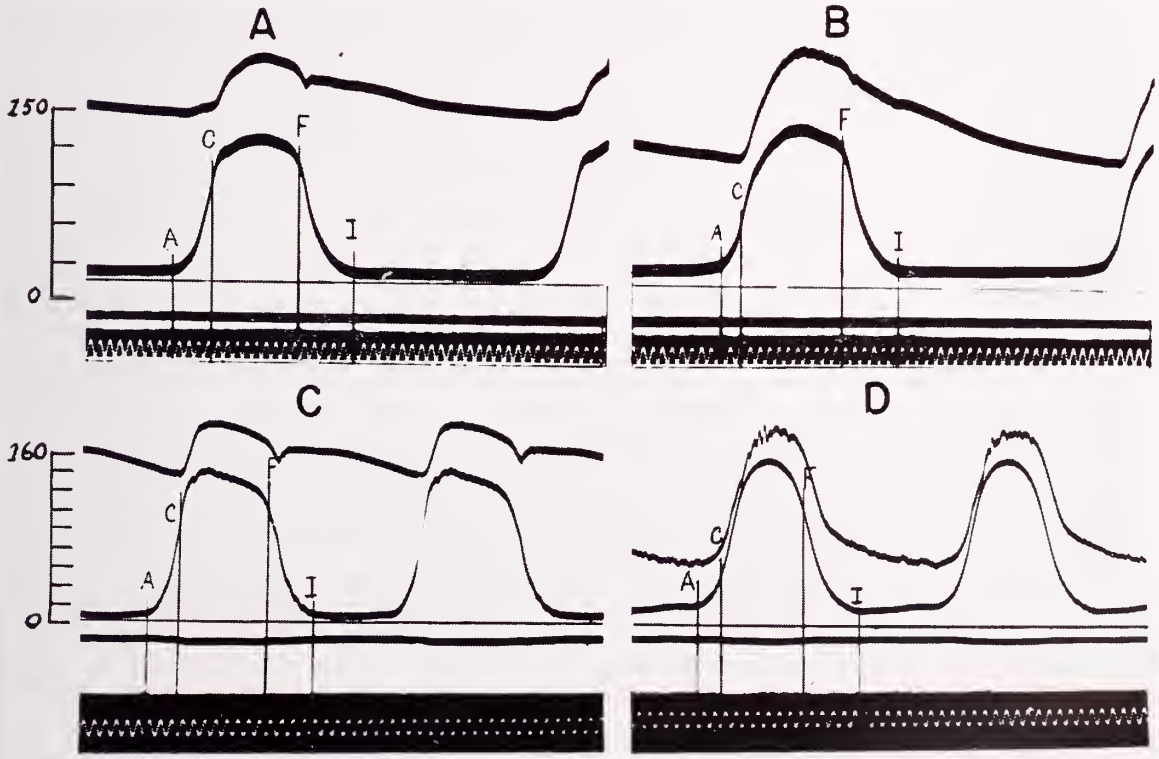


Figure 3. Aortic (upper) and left ventricular (lower) pressure pulses. A and C, Controls; B, after mild aortic insufficiency; D, after severe insufficiency.

Owing to the complicated factors that interact in the transmision of the central pulse to peripheral arteries, the changes in recorded radial and femoral pulses are not as distinctive.[12] However, it has frequently been noted and was confirmed by my tracings that the classical "water hammer" and "collapsing" characteristics are absent in patients unless the degree of insufficiency is very severe.

**Figure 4. Subclavian pulses from patients with mild (Type I) and severe (Type II) aortic insufficiency. Below, heart sounds and murmurs. Note that diastolic murmur in mild insufficiency follows the second sound, and in severe regurgitation replaces it.**

With the progressive improvement in surgical procedure for repair of valvular defects, it will become more and more important to have criteria for estimating the magnitude of valvular defects on a dynamic basis. For this purpose elaborate technics requiring cardiac catheterization have recently been developed. By calculating the mean diastolic pressure gradients between the aorta and left ventricle and assuming certain constants, Gorlin[13] has recently estimated the regurgitant fraction and the size of the leaking orifice in patients. On the basis of their animal experiments, Welch and his associates[14] suggested that mean diastolic aortic pressure[12] multiplied by heart rate is an adequate index of the regurgitant volume. Other efforts are currently being made to evaluate reflux volumes by procedures that involve special analyses of indicator dilution curves. Thus Korner and Shellingford[15] by analyzing the shape of indicator dilution curves obtained data from 7 patients which, upon recalculation, indicate regurgitant fractions of 27 to 74 per cent of the cardiac output. However, cogent arguments have been voiced indicating that current dye dilution methods are not wholly satisfactory; they are certainly complicated in their execution and analysis. It seems questionable to me whether similar lines of study, certainly most uncomfortable and perhaps not entirely without risk to patients, is likely to yield better information than a careful study of central pulse tracings easily recorded with adequate apparatus. At any event, the time has come to ask ourselves whether, like a child with too many toys, we are not becoming so enamored of catheterization technics that we are impelled to employ them in conditions in which simpler procedures would suffice.

### Compensatory Mechanisms

Cardiac compensation is accomplished (a) by normally existing reserve mechanisms that are ready to spring into action the moment that abnormal conditions arise, and (b) by factors that come into existence gradually. In part at least, these take over the task temporarily thrown upon existing reserve mechanisms.

*Compensation by Cardiac Acceleration.*—It seems almost axiomatic that an increase in heart rate lessens backflow by reducing the period of diastole. Tests on artificial circulation models apparently confirm this reasoning (Figure 1). Again we must question the applicability of deductions drawn from logical reasoning and information yielded by artificial circulation machines to the heart. Using a procedure previously described,[11] Warner and Toronto[16] in a preliminary report state that they found the volume of regurgitation in three patients reduced by 39 to 63 per cent when their normal heart rates (60-84 min) were increased to 120 min. by artificial stimulation of the right atrium. However, these must have been instances of mild degrees of insufficiency for a glance at the pressure pulses of Figure 3 strongly indicate that abridgement of diastole could have little effect in severe insufficiency in which most of the backflow takes place during protodiastole.

*End-diastolic Pressure and Volume as the Basic Determinant.*—The dynamic alterations produced by aortic incompetency could inaugurate more powerful ventricular contractions either (a) through actions of neurogenic, humoral, or hormonal agents on ventricular contractility or (b) by operation of physical changes in the input or output loads. While there is at present no evidence that directly acting inotropic factors are invoked, they cannot be excluded. However, as Carl Ludwig, the father of modern physiology, has stated (1868) "the soundest rule of every experimental science (is) that one draw upon only absolutely necessary grounds of explanation." To me the Frank-Starling Law seems adequate to explain the immediate compensatory ventricular reactions in all degrees of aortic valvular insufficiency. As shown in Figures 2 and 3, the elevation of left ventricular end-diastolic pressure explains very well the more abrupt rise of pressures to a higher and earlier systolic peak, the prolongation of the ejection phase and the larger aortic pulse pressure associated with the larger stroke volume.

Since evidence has accrued in recent years[17, 18] that end-systolic ventricular pressure and volume also affect ventricular contraction, it appears likely that the tension-time index proposed by Sarnoff and his co-workers,[19] i.e., the area under the ventricular pressure curve during ejection—serves as a more comprehensive index of ventricular response.

*Cardiac Work and Reserve Capacity.*—With the greater gross output of blood, the compensating ventricle works harder. This is true, not only as regards the mechanical work calculated as the product of the mass of stroke volume and the mean arterial pressure, but also as regards the kinetic factor ($mv^2/2$) concerned in imparting momentum to the blood. Using an ultra-low frequency ballistocardiograph, Honig and Tenney[20] calculated that the kinetic work of the heart in patients with aortic insufficiency may exceed the total cardiac work of normal individuals. The astounding capacity of the heart to carry on is illustrated by experiments of Welch and associates[14] who found that a dog's heart can withstand reflux volumes that are more than 100 per cent larger than the normal output.

When the normal ventricle compensates it does so by reducing its reserve capacity. This had been demonstrated in a qualitative way by previous workers, but has been given a more exact expression by plotting the stroke work against input volumes. Welch et al[14] have recently shown that such ventricular function curves, as they are called, are depressed roughly in proportion to the magnitude of regurgitation.

*Pari passu* with the increased work of the left ventricle its oxygen consumption increases markedly. The magnitude of the increase can, according to Welch and his associates,[14] be estimated by the product of the mean arterial pressure and the duration of systolic ejection. Katz and Fineberg[21] conclude from their studies that no great error in estimating oxygen utilization is made from computations involving only the product of mean arterial pressure and heart rate.

*Coronary Flow.*—The question of whether coronary flow increases in proportion to the greater oxygen requirement is still in doubt, but the weight of experimental and clinical evidence suggests a positive answer. (For recent review see West and associates).[22] Since the marked reduction of aortic pressure during diastole and the increased systolic compression of intramural coronary vessels definitely act to throttle coronary flow, the mechanisms by which a compensatory increase may be attained remain obscure and require further study.

*Ventricular Hypertrophy.*—Ventricular hypertrophy always follows aortic regurgitation both clinically and experimentally. In fact, rupture of the semilunar valves has proved the most effective way for producing left ventricular hypertrophy in dogs. The hypertrophic process starts rather promptly in experimental animals; according to different investigators, in from 6 to 19 days.[7, 23]

It is a reasonable assumption that a ventricle with a large muscle bulk and thicker walls is capable of doing a certain amount of work in a more economical way, thereby increasing its reserve capacity. The assumption is given a measure of support by the microscopical observation that hypertrophy involves not only an increase in sarcoplasm but a greater number of myofibrils as well. However, the idea that the hypertrophied ventricle is a better muscular organ has, for obvious reasons, not been demonstrated experimentally. In this connection we may recall the old clinical opinion that every hypertrophied ventricle is a diseased ventricle which sooner or later fails.

As to the factors responsible for the process of growth that we call hypertrophy, experimental studies have only discounted the roles of infection and cardiac acceleration. Experimentation and clinicopathologic observations have provided circumstantial evidence for the operation of one or several of the following factors: (a) increased ventricular work or strain; (b) anoxia or relative ischemia; (c) intracardiac reflexes; (d) primary ventricular dilatation or increased end-diastolic pressure; (e) temporary injury by stretch of

muscle fibers; (f) physicochemical alterations of the environment; (g) metabolic alterations induced by, or enhanced by, hormonal agents. A careful and unbiased assessment of the evidence does not permit an indictment of any single factor as a prepotent factor. The cause of hypertrophy, the metabolic process by which it develops and the dynamic mechanisms by which it enhances cardiac compensation remain fertile fields for further study.

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# A Professional Obligation

When the Salk vaccine became available to mankind, medical science made its first major breakthrough in the fight against the great crippler, poliomyelitis. For the first time in human history, a child did not have to mature fearing the curtailment of youthful joys because he had been immobilized by infantile paralysis.

Yet the education of the public by the medical profession has somehow failed to reach all the people. Only recently has evidence accumulated to indicate that our old enemy, polio, is on the rise once more and among the groups who seemingly once enjoyed an apparent natural immunity. It is as though the disease, blocked in its usual haunts, had turned to new fields of conquest in its insistence on survival. But this tragedy need not be. In doctors' offices, in clinics and child-care centers, it is our professional obligation to sweep away the fear and ignorance of those less fortunate persons who, through superstition and lack of information, avoid the chance to protect their children.

This is the time of year to complete the protection program which can spell the difference between a lifetime of hurt and sadness or a full, worthwhile existence as a man's rightful heritage. When there is no real barrier against a disease, then we can accept our misfortune, but when protection exists, to become one of life's casualties is needlessly cruel. As physicians let us take up the challenge and protect our citizenry from its own apathy.—Westchester Medical Bulletin.

# Resuscitation*

*David B. Dill, Ph. D.*

I AM honored and pleased to have this opportunity to participate in the celebration of "Van Liere" day. It has been a privilege to have had some discussions with Doctor Van Liere during World War II when we shared an interest in the problem of anoxia. His notable contributions in this field of research, summarized in his book "Anoxia, Its Effects on the Body",[1] have won for him a permanent place in the archives of military medicine and also in the field of respiratory physiology. It has seemed to me fitting today to review postwar studies in a field subsidiary to respiratory physiology, that of resuscitation. I have no unpublished data to present here today; rather I plan to present highlights of postwar basic and applied research in the field of respiratory physiology which have led to the currently accepted method of "rescue breathing."

Research on artificial respiration was initiated by the U. S. Army Chemical Corps in 1949 when it had become evident that existing manual and mechanical methods for resuscitation were inadequate for treating apneic victims of nerve gas poisoning. In 1946 Comroe and Dripps[2] had cast doubt on the efficacy of the Schafer method, a technique of manual artificial respiration in which the victim is prone and pressure is applied rhythmically to the back. Shortly thereafter, the American National Red Cross, through its Executive Committee of the Advisory Board on Health Services, suggested that the Council on Physical Medicine of the American Medical Association consider favorably the appointment of a subcommittee to cooperate with the American National Red Cross on giving advice on technical matters relating to resuscitation.[3]

In 1948, the Army Medical Service and the Red Cross requested the National Research Council to call a conference on resuscitation.[4] This was held in September 1948 under the chairmanship of Dr. James L. Whittenberger. Other members of the committee were Drs. Julius H. Comroe, Jr., Cecil K. Drinker, Allan Hemingway, Hurley I. Motley, Robert F. Pitts and Henry Schwerma. Representatives of the military medical services and also of manufacturers of mechanical resuscitators were present. This conference dealt chiefly with mechanical devices and particularly with the question, "Which is the preferred type of device, one employing intermittent positive pressure or, one depending on positive-negative pressure?" It was emphasized that the first minutes are crucial and that manual methods must be employed because mechanical equipment is rarely at hand. The Schafer method, while imperfect, was recommended because it was widely known and could be employed immediately by one person.

The need of the military services for a portable, manually operated resuscitator was recognized and its characteristics specified. It was decided that there was insufficient evidence presented to decide between the two types of mechanical devices—intermittent positive pressure and positive-negative pressure. The committee recommended that a research program be initiated within the laboratories of the armed forces and possibly elsewhere to provide additional data on the relative physiological effects of the use of the two types of apparatus. It is noteworthy that at this conference Motley suggested the need to consider the mouth-to-mouth method of insufflation and that Behnke proposed a face mask with a tube for mouth-to-mouth insufflation.

The interest of the Chemical Corps in respiratory physiology and in resuscitation stems from the fact that chemical warfare agents commonly interfere with respiration. Research in this field in particular and in the broad fields of biological and medical aspects of chemical warfare has been a responsibility of the Chemical Corps since World War II. The Medical Services of the Department of Defense look to the Director of Medical Research, Chemical Warfare Laboratories, for basic and applied research in these fields. This research forms a basis for defensive applications, including first aid and treatment


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*Presented in connection with a special program honoring Dr. Edward J. Van Liere, Dean, West Virginia University School of Medicine, which was held at the Medical Center in Morgantown on May 12.

measures and for the preparation and up-to-date revision of training manuals.*

An exploratory conference was held at the Army Chemical Center in June, 1949.[5] The stimulus for reaching an early decision regarding the methods of manual artificial respiration came in early 1950. In January of that year, the Secretary of Defense asked for a revision of the Training Manual, "Treatment of Casualties from Chemical Warfare Agents." A task force consisting of Colonel John R. Wood, MC, Army; Commander Paul F. Dickens, MC, Navy, and Major John Rizzolo, MC, Air Force, was assigned this task. They were confronted with new evidence, including the hip-lift method proposed by Emerson,[6] studies of the hip-lift prone-pressure and other methods by Gordon, Ivy, and associates, 1950,[7] and various reports on the inadequacy of the Schafer method, especially the study by Comroe and Dripps (loc. cit.). It was therefore decided to call a third conference at the Medical Laboratories, September 29-30, 1950.[8]

Among those invited were experts in the field of respiratory physiology, representatives of the Red Cross, of the U. S. Public Health Service, and of manufacturers of equipment. A prominent part was taken in that conference by representatives of research and development in the three military medical services, including Colonel John R. Wood, Army; Captain O. D. Yarbrough (representing Captain Shaw), Navy, and Colonel A. P. Gagge, Air Force. It was agreed that there should be a concerted attack on the problem of manual artificial respiration. Research with a well-defined goal was required, i. e., "What method or methods are best adapted for military use?" This report has been a useful guide for investigators in the field of respiratory physiology and for staff officers who make decisions about methods and equipment. Subsequently I was requested to help set up and coordinate a program of research on manual artificial respiration.

The history of events during the next year illustrates an effective attack on a military medical problem. First of all, the problem had to be defined. This was accomplished at the conference held September 29-30. Authoritative views were expressed by staff officers of the three medical services and of the Chemical Corps. Secondly, an exchange of views among experts in the medical sciences crystallized ideas about the research required. Thirdly, investigators had to be found and funds required had to be estimated and made available.

A planning meeting was held in Washington on November 8, 1950. Of those present, four agreed to undertake short-term research projects: Drs. Comroe, Gordon, Karpovich and Whittenberger. The cost was underwritten by the three military medical services operating through the Office of Naval Research. Drs. Comroe and Whittenberger proposed studies of apneic patients that might become available in hospitals in Philadelphia and Boston, respectively. Their studies were to include measurements of lung function and observations on respiratory volume and pattern during the application of various manual methods. When feasible, blood pressure and air-way resistance would be measured. Doctor Gordon proposed measurements of lung ventilation during the application of various manual methods to healthy apneic males. On some of these he planned to measure oxygen uptake, arterial oxygen saturation, cardiac output, and fatigue induced in the operator.

Doctor Karpovich proposed three studies. In the first, pulmonary ventilation was to be measured on healthy conscious subjects, male and female, subjected to the various manual methods. While most investigators have frowned on data so obtained, it seemed worth a try. Coupled with the foregoing, the energy used by the operator in applying the various methods was to be measured. The third and most important study concerned pedagogical and operational factors: degree of difficulty in learning and teaching the various methods of manual artificial respiration, and fatigue and discomfort engendered in administering them. Karpovich had available essential equipment familiar to respiratory physiologists plus the help of an able staff and an enthusiastic group of students. Dr. Archer S. Gordon, an investigator with Chemical Corps support and with encouragement from the American National Red Cross, conducted research in this field also.

The principal investigators were called to meet with representatives of the medical services, the U. S. Public Health Service, and the American National Red Cross on April 3, 1951. Preliminary results were reported and ideas generated by the

*The original Medical Division, activated in July 1943, consisted of the Office of the Chief, Medical Division, in Washington, D. C.; the Medical Research Laboratory and the Toxicological Research Laboratory at Edgewood Arsenal (now Army Chemical Center); a toxicological research laboratory at Camp Sibert, Alabama; a medical research laboratory at Dugway Proving Ground, Utah; and a mobile field unit at Bushnell, Florida. At the end of the War all units, except the two laboratories at Edgewood Arsenal, were discontinued. These two laboratories were combined in September 1945 to form a consolidated Medical Division, which continued until 1951, when it became the Medical Laboratories of the Army Chemical Corps. In February 1956 the Chemical Corps again reorganized its research, consolidating the Chemical and Radiological Laboratories and the Medical Laboratories to form the Chemical Warfare Laboratories. The former Medical Laboratories became the Directorate of Medical Research, including all of the former research branches except part of those in Biochemistry Division. Further reorganization led to a change in the name of Chemical Warfare Laboratories to Chemical Research and Development Laboratories.

six months' research were exchanged. It was agreed that two methods, arm-lift back pressure and hip-lift back pressure, were superior to the Schafer method. It was further agreed that the success of any method depends on thoroughness of indoctrination and that further studies were required before details of techniques could be recommended. It was decided that Drs. Gordon and Karpovich would collaborate in evaluating the two favored methods with attention to teachability and ease of learning, working out refinements of techniques and in redrafting descriptions of the two methods. These tasks were accomplished with the help of the National Opinion Research Center at the Great Lakes Naval Training Station, using Naval recruits and Waves.

The American National Red Cross kept abreast of these investigations. When it appeared that definitive results had been obtained, the Red Cross requested the Division of Medical Sciences, National Research Council, to organize a committee to review the findings of the four investigators and to report to representatives of interested agencies. The conference was held on October 1, 1951; and it was my privilege to act as chairman.[9] Immediately after this conference the Red Cross announced publicly its adoption of the back-pressure arm-lift method. A full description on this method can be found in the 1957 edition of its manual and in the *U. S. Armed Forces Medical Journal*.[10]

A valuable historical document that evolved from this program was an account of various methods of resuscitation, ancient, medieval and modern, written by Peter Karpovich in his usual colorful style.[11]

While manual methods were being studied, two medical officers assigned to the Army Chemical Corps, Drs. Richard J. Johns and David Y. Cooper III, conceived the idea of a mask-to-mask resuscitator suitable for use on nerve gas casualties in a contaminated atmosphere.[12] This device is being developed by the Army Chemical Corps; it is anticipated that it will be standardized by the three medical services for military use. Dr. James O. Elam, with support from the Office of the Surgeon General, Department of the Army, and his associate Dr. Elwyn Brown were early investigators both of mask-to-mask and mouth-to-mouth artificial respiration.[13] They continued their studies while assigned as medical officers to the Army Chemical Corps and afterwards at the Roswell Park Memorial Institute, Buffalo, New York.[14] Dr. David Greene of the University of Buffalo and Dr. Peter Safar of the Baltimore City Hospitals, both supported by the Office of the Surgeon General, Department of the Army, have joined forces with them in collaborative studies.[15,16,17] Dr. Archer S. Gordon has continued his research in this field also.

The American National Red Cross continued to give close attention to research on resuscitation, particularly the mouth-to-mouth method. In addition its attention was called to a proposed adaptation of the Eve rocking method to the resuscitation of infants and small children. The efficacy of a rocking procedure which did not require equipment was championed by Captain Rickard based on his personal experiences.[18] At about the same time, he asked the Red Cross to consider adopting his method. Because of his request and the accumulating body of experimental observations on mouth-to-mouth resuscitation, the NAS-NRC decided to call another conference on artificial respiration. An ad hoc committee appointed by the Division of Medical Sciences met at the Academy on March 8, 1957. The committee members were as follows:

David B. Dill (Chairman), Julius H. Comroe, Jr., Robert D. Dripps, Archer S. Gordon, Howard G. Swann, James L. Whittenberger, James O. Elam and M. H. Sloan of the NAS-NRC staff. Those called in as discussants were: Virginia Apgar, H. J. Rickard, Clement A. Smith, Peter Safar, and Earl H. Breon of the American National Red Cross.

Mr. Breon stated the need of the Red Cross for advice in this field. A rocking method for infants and small children up to 30 lb. in weight and 34 in. in length was described by its advocate, Captain Harold J. Rickard, MC, U.S.N. Experiences with mouth-to-mouth breathing were presented by Drs. Apgar, Elam, Gordon, Safar and Smith.

After hearing the evidence, the panel in executive session agreed to the following recommendations:

The data available on the effectiveness of the manual rocking method of artificial resuscitation for infants and small children advocated by Captain H. J. Rickard are not sufficiently convincing at this time to warrant a recommendation that the American National Red Cross include a description of this method in the forthcoming revision of their first aid manual. Instead, the panel recommended that for emergency resuscitation of infants and small children, a description of mouth-to-mouth resuscitation, following a preliminary maneuver to clear the airway, should be included in the revised manual. It was also recommended that all possible media of public information be utilized to disseminate information concerning the use of this method for infants

and small children and that this be made a part of the instructions given to new mothers when discharged from maternity hospitals.

In the panel discussion which led to the above recommendations, the opinion was unanimous that the mouth-to-mouth method for infants and small children was preferable to the rocking method, back-pressure arm-lift, and other manual methods. The evidence was convincing that the latter methods may fail to ventilate the lungs adequately. The panel requested Doctor Gordon to draft a description of the mouth-to-mouth method which was, in due time, circulated to other members for comment. Based on this description of the technique and of the recommendation of the panel previously quoted, the American National Red Cross prepared instructions for use by the lay public in the resuscitation of infants and small children. These were published in the 4th Edition of its manual (loc. cit) and also in the *U. S. Armed Forces Medical Journal* and in the *Medical Technicians Bulletin.*[19]

Later in 1957, a conference was held in Denver to discuss the topic, "Artificial Respiration in Nerve Gas Poisoning." An agreement was reached at that time to prepare a symposium on mouth-to-mouth resuscitation; this was published in 1958. [20, 21, 22, 23] It was also agreed that a book should be written on "Artificial Respiration. Theoretical and Applied," with major roles assigned to Comroe and Whittenberger. This project is now well under way. The contributing authors include most of those who have conducted research in this field with support from the military services.

Viewed in retrospect, the use of an artificial airway has played a major role in affecting experimental results and in influencing current doctrine. Gordon and associates used an endotracheal tube in some of their apneic anesthetized and curarized volunteers from which was derived evidence supporting the back pressure-arm lift method.[7] They did not realize at the time the degree to which this device insured the success of the procedure. It has since been shown by Safar[23] that without an endotracheal tube manual methods, including the back-pressure arm-lift method, are apt to fail.

Current views are somewhat divergent as to the emphasis that should be placed on the use of an artificial airway in brochures and films aimed to teach rescue breathing. All agree that in emergencies with no airway at hand one should proceed without it. Some believe as do I, that if an oropharyngeal airway is purchased from a drug store and is put in a "safe" place in the home, looking for it in an emergency may waste enough time to lose a life that might have been saved. It appears to me that resuscitation is such a rare event in most of our lives that only in special cases should there be any suggestion than an adjunct is needed for rescue breathing.

The forerunner in perfecting rescue breathing and in publicizing the technique is James O. Elam, Director, Department of Anesthesia, Roswell Park Memorial Institute, Buffalo 3, New York. The brochure entitled "Rescue Breathing" he and his associates have prepared has been distributed widely by the New York State Commissioner of Health, Dr. Herman E. Hilleboe. Doctor Elam has demonstrated that simply tilting the head of the supine victim back as far as possible prevents the tongue from blocking the airway. Also he recommends "mouth-to-nose" unless the nose is found to be obstructed. To those who desire the last word on rescue breathing, I recommend addressing a request to Doctor Elam for this latest brochure.

In summary, it has been my privilege to report to you today recent advances in resuscitation that will lessen the incidence of death from asphyxia of many sorts. Doctor Van Liere, when you write a new edition of your book, you may wish to include a chapter on "rescue breathing."

I wish to acknowledge my debt to many colleagues who have contributed to the basic and applied research which has culminated in a new life-saving procedure. Their names are mentioned in the text or in the bibliography.

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# Role of the Aged in American Society

America is a society which does not have the excuse of poverty to encourage it to consider its aged as burdens. America is the world's wealthiest society, past or present. Certainly it has no economic reason to fail to provide adequately for its aged. True, Americans no longer take seriously the notion that the ghosts of the aged will haunt them if they mistreat them, but then Americans sometimes like to believe they have substituted for superstition a higher ethic of human consideration and worth. This ethic, on a societal basis at least, seems to break down when applied to the aged.

Americans seem not to have provided the essential value orientation to their aged quickly and humanely or to assist them to live in comfort and in dignity. Indeed, if with respect to the aged, there is one charge that can be leveled against American society, it is that it has really not yet adequately defined the situation for them or its other citizens. In a sense, Americans have tried to sweep the whole matter of age and of growing old under the rug, with the naive implication that if they don't talk about the issue, it will somehow disappear.

Most people tend to shy away from an open and honest concern with age and aging because that is a way, however juvenile, of repressing it and pretending it can't happen to them. If, apart from dying, there is anything else this youth-oriented society fears it is growing old. Consider the entire set of cultural things, attitudes and ideas Americans have devoted to the defeat of age: books by the dozen are published every year to teach them how to feel younger, cosmetic preparations by the thousands of tons are manufactured each year designed to make them look younger; clothes are advertised to accent that "youthful appearance"; these and other cultural elements all contribute to the development of an overwhelming youth fixation. Americans have reached the paradoxical point where people are ashamed to acknowledge their age because they realize the extreme pressure to remain young.—Mel J. Ravitz, Ph.D., in Industrial Nurses Journal.

# The Relation of Timed Vital Capacity to Maximum Breathing Capacity

*David W. Northup, Ph. D.*

In the last few years there has been a steady increase in the use of physiologic tests for the evaluation of pulmonary function. Since these tests provide quantitative data, they are becoming increasingly popular in the assessment of the degree of disability caused by cardiopulmonary disease. A discussion of the techniques and relative merits of the various tests available may be found in Comroe et al.[1]

Recently a publication[2] distributed by a company which sells equipment for pulmonary function tests suggested that the maximum breathing capacity may be calculated from the one second vital capacity by multiplying by an empirical factor of 38. The anonymous author makes the reservation that the figure obtained for the maximum breathing capacity by this method may sometimes be higher than that obtained in the direct test since fatigue is not taken into account, but "apart from this objection the method is useful . . ." To get even fair accuracy there would have to be a very high degree of correlation between 1 second vital capacity and maximum breathing capacity. Gaensler[3] reported a coefficient of correlation of 0.88 between these variables in 227 subjects (35 normal, 118 with restrictive pulmonary defects, and 74 with obstructive defects). This is not high enough for good predictive value. He states that the correlation "will be the greater the larger the number of patients with restrictive defects included in the group under investigation." In other words, the correlation is poor in patients with obstructive defects. This group was a minority in his series. He does not give separate coefficients for his three groups. For his data, the ratios of maximum breathing capacity to 1 second vital capacity are: normals, 41; restrictive defects, 27; and obstructive defects, 24.

Data collected in the Department of Physiology of the West Virginia University Medical Center during the past year give even lower correlations than Gaensler's figures, with very wide variations in the ratio.

### Methods

The 1 second vital capacity was determined with a Gaensler-Collins Timed Vitalometer. Maximum breathing capacity was determined by having the subject breathe with maximum effort for fifteen seconds through a high-speed respiratory valve (made by Hans Rudolph, Mission, Kansas) into a high velocity dry test gas meter (American Meter Co., sold by Phipps & Bird). There were 69 normal subjects, including 61 males and 8 females, and 23 patients with a variety of pulmonary defects, including emphysema, silicosis, and asthma. These latter were referred by the Disability Determination Section of the Vocational Rehabilitation Division of the West Vrginia State Board of Vocational Education; they were all males between the ages of 50 and 64 and all were applying for social security payments on the grounds of total and permanent disability. The normal subjects were all students between the ages of 20 and 30. The patients were definitely not motivated to do their best; the students were.

### Results

The results, together with statistical analysis, are summarized in Tables I and II. From Table I it may be concluded that the 1 second vital capacity of the students is not correlated at all well with the maximum breathing capacity. The r value of 0.47 indicates some degree of correlation, but not nearly enough for predicting one from the other. Furthermore, the ratio of 33 is considerably different from the 38 suggested in reference 2. The patients show somewhat better correlation (an unexpected result), but still not good enough for prediction, and their ratio is only 35.

Table II gives some idea of the variation encountered. The 95 per cent range is calculated by taking two standard deviations on either side of the mean. In the patients this calculated range shows values ranging all the way from 10 to 60. The actual range in the sample was 15 to 77, a pretty good agreement considering the


## *The Author*

- **David W. Northup, Ph. D., Professor and Chairman, Department of Physiology, West Virginia University School of Medicine, Morgantown, West Virginia.**

smallness of the sample. With this sort of variation it is obvious that a maximum breathing capacity calculated from the 1 second vital capacity is of little or no value.

### Discussion

It is not at all surprising that the timed vital capacity and the maximum breathing capacity do not correlate very well. The timed vital capacity depends to a large degree on expiratory muscle power and airway resistance to air moving out, with other factors playing a minor role. The maximum breathing capacity, on the other hand, brings in the additional factors of the non-elastic resistance of the lungs, inspiratory muscle power, compliance, volition, skill, and coordination to a much greater degree. The last three factors named are very difficult to measure, and undoubtedly contribute greatly to the high variance found for maximum breathing capacity. It is also notorious that different kinds of apparatus give different results for the maximum breathing capacity, and there is more than a suspicion that different investigators giving different instructions to the subjects may obtain differing results on the same apparatus.

The two series reported in this paper are rather small. The matter of the correlation between the timed vital capacity and the maximum breathing capacity could stand further investigation using large series of subjects both normal and with pulmonary defects.

### Summary

In 69 normal subjects the coefficient of correlation between the 1 second vital capacity and the maximum breathing capacity was 0.47. The average ratio between the two factors was 33. In 23 patients with pulmonary defects, the coefficient of correlation was 0.67, the ratio 35. There was a high degree of variation in the ratios. It is therefore not practical to use timed vital capacity to calculate the maximum breathing capacity.

**TABLE I.**

| | *No. of Subjects* | *1 Sec. Vital Capacity Liters* | *Maximum Breathing Capacity Liters/min.* | *Correlation Coefficient, r* | *Average Ratio, MBC/1 Sec. VC* |
|---|---|---|---|---|---|
| Students | 69 | 4.09 | 134.6 | 0.47 | 33 |
| Patients with pulmonary defects | 23 | 1.62 | 52.3 | 0.67 | 35 |

**TABLE II.**

| | 1 Second Vital Capacity | | Maximum Breathing Capacity | | Ratio, MBC/1 Sec. VC | |
|---|---|---|---|---|---|---|
| | *Standard Deviation* | *95% Range* | *Standard Deviation* | *95% Range* | *Standard Deviation* | *95% Range* |
| Students | 0.67 | 2.74-5.42 | 28.2 | 78.2-191.0 | 6.5 | 20.3-46.3 |
| Patients with pulmonary defects | 0.75 | 0.12-3.12 | 21.8 | 8.7-95.9 | 12.2 | 10.5-59.3 |

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# Accident Prevention Programs

A local poison control program may have the potential of saving only five lives a year, whereas making the requirements for driver licensing much more drastic may have the potential of saving 50 lives a year in the same community.

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The latter program is much more remotely associated with accident prevention, its beneficial effects are more difficult to appreciate, it involves more deprivation of personal liberty (a license), and hence must await the preparation of the community mind for its fulfillment. This may take many years.—Albert L. Chapman, M. D., in Public Health Reports.

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1. Innerfield, I.: Clinical report cited with permission
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# Special Article

## 'This Is Your Life—Dean Van Liere'*

*Sobisca S. Hall, M. D.*

It would indeed be "carrying coals to New Castle" if I were to undertake to retrace Dr. E. J. Van Liere's educational path or to restate his professional achievements and intellectual attainments. Suffice it to say that all of these have been of sufficient importance as to assure him of a solid niche in the history of the West Virginia University School of Medicine and an unmatched place in the lives of the students for whom he has given so fully of his time, thought and energy.

Tonight, it is my privilege and pleasant duty to try to deal in a small way with the philosophy that has held steady during Doctor Van Liere's tenure of office here at the University and to try in my humble way to analyze a part of the effects of this philosophy upon him, his students and eventually all the patients with whom his students come in contact.

As you know, Doctor Van Liere has devoted generously of his time to writing. Why has he given the time and gone to the trouble of writing? He made up his mind early in life to make a career of the teaching of young men and women who were to dedicate their lives to the care of the sick and injured. This philosophy is beautifully expressed in Will Allen Dromgoole's poem, *The Bridge Builder:*

An old man going a lone highway
Came at the evening cold and gray
To a chasm vast and deep and wide.
The old man crossed in the twilight dim,
The sullen stream had no fears for him,
But he stopped when safe on the other side
And built a bridge to span the tide.

"Old man," said a fellow pilgrim near,
"You are wasting your strength with building here,
Your journey will end with the ending day,
And you never again will pass this way.
You've crossed the chasm deep and wide;
Why build you this bridge at evening tide?"

The builder lifted his old gray head,
"Good friend, in the path I have come," he said,
"There followeth after me today
A Youth whose feet will pass this way.
This chasm which has been as naught to me,
To that fair-haired youth might a pitfall be;
He, too, must cross in the twilight dim,
Good friend, I am building the bridge for him."

*Presented in connection with a testimonial dinner honoring Dr. E. J. Van Liere, sponsored by the faculty and members of the first and second year classes of the West Virginia University School of Medicine, and held in Morgantown on May 6, 1960

### *The Author*

- **Sobisca S. Hall, M. D., 132 South Fourth Street, Clarksburg, W. Va.**

Doctor Van Liere is a respected medical educator who has played a large part in the building and maintenance of the high standards of medical education at West Virginia University School of Medicine.

He has an abiding interest in the individual student and is a genuine friend of the hundreds of former students for whom he shared teaching responsibilities. I believe this facet of his philosophy is best expressed in the poem by Foss, *The House by The Side of The Road:*

Let me live in my house by the side of the road
Where the race of men go by;
They are good, they are bad, they are weak, they are strong,
Wise, foolish — so am I.
Then why should I sit in the scorner's seat,
Or hurl the cynic's ban?
Let me live in my house by the side of the road
And be a friend to man.

Eddie, as he is affectionately referred to by his former pupils, has seen the second generation students, the children of his earlier students, enroll and graduate under his tutelage, among them being the speaker and his son.

What has this heritage of Doctor Van Liere's given to you? It has given you the opportunity to acquire a real American creed. I should like to quote from an unknown author what he considered a real American Creed:

"I do not choose to be a common man. It is my right to be uncommon if I can. I seek opportunity—not security. I do not wish to be a kept citizen, humbled, dulled, by having the state look after me. I want to take the calculated risk, to dream and to build, to fail or succeed. I refuse to barter incentive for a dole. I prefer the challenges of life to the guaranteed existence; the thrill of fulfillment to the state calm of Utopia.

"I will not trade freedom for beneficence, nor my dignity for a handout. I will never cower

before any master nor bend to any threat. It is my heritage to stand erect, proud and unafraid; to think and act for myself; to enjoy the benefits of my creation, and to face the world boldly and say: . . . this I have done."

It has given you a real chance for service. It has given you a chance to grow in wisdom and stature and favor with God and man. This is so perfectly expressed by the great Dr. Oliver Wendell Holmes in "*The Chambered Nautilus*":

> Build thee more stately mansions, oh, my soul,
> As the swift seasons roll!
> Leave thy low-vaulted past!
> Let each new temple, nobler than the last,
> Shut thee from heaven with a dome more vast,
> Till thou at length art free,
> Leaving thine outgrown shell by life's unresting sea!

It has given you the ability to decide largely your own destiny. Dr. Gordon Myers of Boston has provided us with this thumb-nail sketch of the man *least* likely to have coronary heart disease:

"An effeminate municipal worker or embalmer, completely lacking in physical and mental alertness and without drive, ambition or competitive spirit, who has never attempted to meet a deadline of any kind. A man with poor appetite, subsisting on fruits and vegetables laced with corn and whale oil, detesting tobacco, legitimate libido, and other honorable pleasures; spurning ownership of radio, TV, or motor car, with a full head of hair, yet scrawny and unathletic in appearance; constantly straining his puny muscles by exercise; low in income, blood pressure, blood sugar, uric acid, cholesterol and ambition, who has been taking nicotinic acid, pyridoxine and long term anticoagulant therapy ever since his prophylactic castration."

It has given you qualities that fit you for decisions within the profession where controversies exist.

There will almost certainly be times, events and circumstances when to sit still and refrain from expressing an opinion will be the easier, but if the Medical Profession is to maintain its high and deserved rank, you must defend principle against every antagonist in or out of the profession. Such defense will scar you with the marks of many battles, but in the final count, you will be rewarded richly even by your antagonists. Franklin had an excellent philosophy for these circumstances when he said:

> No man's person I hate though his conduct I blame,
> I can censure a vice without stabbing a name.
> To amend—not reproach—is the bent of my mind.
> A reproof is half lost when ill nature is joined.
> Where merit appears, though in rags, I'll respect it
> And plead virtue's cause, should the whole world
> reject it.

It has given you the opportunity to acquire the intellectual honesty buttressed by an unshakable faith in the Supreme Being so necessary to blend Science into the fabric of your belief and trust in God.

Belief in God and Evolution are not incompatible. John Burroughs, one of our greatest naturalists said: "To me God is a greater God by having created hundreds of thousands of feet of earth upon living organisms in order to have a place worthy of man, the being whom he created in his own likeness, than if he had done it all at once."

That both plants and living creatures are common throughout the Universe must now be taken as highly probable, though it cannot yet be proved beyond doubt. We may be hopelessly conservative if we guess that life may be associated with one star in every hundred. In his book, "Of Stars and Men," Dr. Harlow Shapley reduces the figure to one in a million. But, at the present stage of our semi-ignorance, any figure is pure guesswork, but for the sake of argument, let's settle on that one in a hundred and see where it leads us.

It implies the existence of a billion life-bearing worlds in our single galaxy—the whirlpool of stars of which our sun is an undistinguished, out-of-town member, lying in one of the more remote spiral arms. And, within the range of our telescopes, there are approximately a billion other galaxies. A billion is a number all too familiar in today's budgets and military estimates, but this does not mean that anyone can visualize it. Should you feel like trying, I recommend this simple and highly instructive experiment:

Go down to the nearest beach and collect a bucketful of sand. Then bring it home and empty it on the table. You now have in front of you, assuming that the sand is of reasonable fineness, something like a billion separate particles. Sift them through your fingers. Each is a distinct entity, different from all its companions. How long would it take you to examine every clearly visible individual in the quite small pile before you? Devoting one minute to each and working eight hours a day, the project would keep you busy for almost six thousand years—the whole span of recorded human history. That is what a billion means. Now try to imagine that every one of these grains of sand is itself a world, perhaps teeming with life, and perhaps bearing rational creatures who measure their history not in thousands but in millions of years. If you succeed, you have a faint mental picture of the Universe; however, the operation must be repeated with each grain of sand now representing an entire

galaxy. This vast, infinite acceptance gives God grandeur beyond our small earth concept and easily sustains me in my faith in Him.

It has given you the broad educational base that if used wisely and built upon properly should permeate you with the philosophy that comes at the end of the road, and in the evening of life you may be able to say with Tennyson in his incomparable poem, "*Crossing The Bar*"

Sunset and evening star,
And one clear call for me!
And may there be no moaning of the bar,
When I put out to sea,

But such a tide as moving seems asleep,
Too full for sound and foam,
When that which drew from out the boundless deep
Turns again home.

Twilight and evening bell,
And after that the dark!
And may there be no sadness of farewell,
When I embark;

For though from out our bourne of Time and Place
The flood may bear me far,
I hope to see my Pilot face to face
When I have crossed the Bar.

To Dr. Edward J. Van Liere, husband, father, grandfather, citizen, physician, teacher and moulder of the minds and lives of young physicians, author, Dean and soon to be Dean Emeritus, these are some of the ideals, events and personalities that have enriched our lives and ennobled your character.

Eddie, "This is your life!"

---

# Animal Diseases in Man

World Health Organization lists more than 100 animal diseases transmissible to man, and a number of infections common to man and animals. Nearly all are long standing zoonoses (diseases including infections which are naturally transmitted between animals and man) except some recently described viral infections.

The recent description of ECHO and adenoviruses in cattle, swine, cats and chickens as well as coxsackie virus in rodents, suggests the possibility that animals may harbor infectious agents that are beginning to emerge as zoonoses. What is the potential public health importance of animal influenza, parainfluenza and other newly identified respiratory agents? The answer awaits investigation by the medical researcher, the epidemiologist and the veterinary public health specialist.

Among the viral diseases that affect man and animals the most important is rabies. The magnitude of the problem is indicated by the number of persons required to undergo antirabies treatment. It is estimated that the number bitten by animals each year exceeds 600,000. Thirty thousand of these are required to take antirabies treatment either because they were bitten by rabid animals or by stray animals not available for examination. Dogs are the greatest offenders, followed by cats, foxes and skunks, and occasionally bats.

The dog and cat population is estimated at 50,000,000 or more, double that of 15 years ago. If this population doubles in the next 15 years, it will exceed 100,000,000. This is entirely possible, since humane authorities estimate that 86,000,000 puppies and kittens were born in 1957 alone. Fortunately, a large number do not survive. It is important that those taken into households be immunized against rabies to prevent them from becoming carriers.

The most interesting rickettsial zoonosis is Q fever, no longer a rare disease. Q fever has been reported in cattle as well as in sheep and goats. The infection is benign in animals, even though at parturition the placenta may be teeming with Coxiella burnetii, the causal agent. Control is difficult because of the benign nature of the disease. The enormity of the task is compounded by the size of the susceptible animal population. There are more than 100,000,000 cattle, 30,000,000 sheep and 1,000,000 goats in the United States.

The most important of the bacterial zoonoses is brucellosis. Fortunately the national brucellosis campaign has reduced its prevalence in cattle in most parts of the country, but the disease in swine remains a serious problem. The eradication of brucellosis in all domestic animals is possible but will require the support of everyone concerned.

Public healthwise, the most important aspect of brucellosis in 1960 is the high rate of occupational disease among hog farmers and butchers. The annual swine population of our country exceeds 100,000,000 of which 1,500,000 are estimated to be infected by brucella. Porcine brucellosis is not only a threat to human health but its spread can undo the excellent control work already accomplished in cattle.—James H. Steele, D. V. M., M. P. H., in International Medical Digest.

# Special Article

# William Beaumont and the Mysteries of Digestion

*Edward Podolsky, M. D.*

If Alexis St. Martin hadn't been careless and gotten himself shot full of lead he almost certainly would have lived and died a trapper in the North Country like thousands of other trappers. And there wouldn't have been this story to tell. But because Alexis did get in the way of a full charge of gunshot fired at close range, his name has gone down in history, and all because William Beaumont, a young surgeon with an overwhelming sense of curiosity, happened to be available at the time.

It happened in the American Fur Trading Company's store on the morning of June 6, 1822. The store was crowded with a motley crew of Indians, half-breeds, trappers and *voyageurs* who had brought in their winter's collection of pelts to do a bit of bartering and story-swapping. One of the trappers was a bit careless with his gun; it went off and Alexis St. Martin dropped to the floor. There was a dreadful, hushed silence and then someone remembered to summon Doctor Beaumont.

The young surgeon came hurriedly, fought his way through the crowd and examined the wounded man. A portion of the lung, as large as a turkey's egg, was protruding through the wound. Below this was another protrusion which looked like a portion of the stomach. Beaumont marvelled that Alexis was not dead. On further examination, he saw that the man was still breathing and that the second projection was indeed a portion of the stomach, with a hole in it large enough to admit his forefinger and through which food, eaten only a short time before, was escaping. Matters were far from reassuring.

But Doctor Beaumont was not discouraged; he swung into action. Before he could push the protruding lung back into place he was obliged to cut off with a pen knife the point of a fractured rib on which it was caught. Even then it was necessary to hold the lung in place by pressure.

A dressing was applied to the ugly wounds and the young Canadian was removed to the crude wood shack which was Mackinac's only hospital. There, within an hour, Doctor Beaumont did a more thorough job. He had to remove bits of clothing, charges of shot and fragments of rib which had been driven into the badly lacerated tissues. There was no ether in those days, and the pain must have been maddening, but young Alexis St. Martin, who was only nineteen, endured it all with scarcely a whimper.

The wound that St. Martin had received was not the kind that heals in a hurry. There had been extensive destruction of tissue; infection and corroding stomach acids that had leaked through had added to the difficulty. St. Martin remained in the shack that was called a hospital for a long time. Day after day, for almost a year, Beaumont was in attendance on the young Canadian, dressing and treating the gaping wound which would not heal. It seemed continually to become infected; abscesses had to be opened and drained, pieces of bone had to be removed.

The treatment seemed interminable. By April, 1823, the town officials had begun to rebel. Young Alexis had, it seemed, become a permanent patient, a serious drain on the town's meager treasury. The town no longer could afford to take care of him. He was to be shipped off to his native city. Beaumont would not hear to it; he had formed an attachment for his young patient. He was very much interested in seeing what the final outcome would be. So he removed the young trapper to his own home where he continued to feed, nurse and treat him, at his own expense.

Within another year Alexis St. Martin had gained back his health but the wound in his stomach remained unhealed. He became a mem-

***The Author***

- **Edward Podolsky, M. D., 1049 East 18th Street, Brooklyn 30, New York.**

**Submitted to the Publication Committee, June 17, 1960.**

ber of Beaumont's household and earned his keep by making himself generally useful around the house.

* * *

Here the story would have ended had young Doctor Beaumont been merely a surgeon and nothing more. But Beaumont was one of those who possessed an endless curiosity about mysterious and perplexing human processes. And here was a grand opportunity to learn something about how the stomach acts, how it functions, how it converts food into living energy and tissue. In the course of his daily treatment of the wound in the stomach, Beaumont had seen that when Alexis lay on his right side so that the stomach swung away from its attachments to the margins of the healing wound he could actually look directly into its cavity and almost see the process of digestion. He saw also that fluids poured in through a funnel could later be removed by siphonage. In this recovered fluid were morsels of different kinds of food. When this fluid was recovered at different times the food particles were at different stages of digestion. Beaumont was exploring new territory, finding out new facts that never before had been known. He was exploring the mysteries of human digestion.

Doctor Beaumont wrote down these preliminary observations and sent them off to the Surgeon General. Beaumont was now thinking digestion, breathing digestion, living digestion. He wanted to know all about a process which at that time was very little understood. His searching in the books yielded only a few meager facts.

He learned that Van Helmont, who loved to dabble in alchemy, had made some interesting contributions to the knowledge of how the stomach and intestines converted food into living tissue. Van Helmont, being a chemist, saw the whole process as a series of chemical reactions. But a contemporary, Borelli, took violent exception to Van Helmont's theory and maintained that digestion was simply a mechanical process. It remained for Dr. Herman Boerhaave, the leading Dutch medical authority of those times, to combine both views, i.e., that digestion was both a chemical and a mechanical process. He thus arrived at a truer conception of the mechanism of this very important human function.

Thereafter, doctors began to learn rapidly about the mysteries of digestion. Sylvius, in the 17th century, found that the juices of the mouth, stomach and intestines entered profoundly into the process. His pupil, the 22-year-old Regner de Graaf, was not content to work in the dark. He wanted to see with his own eyes how these potent digestive juices worked. From a living duck, by means of a duck's quill, he obtained a quantity of pancreatic juice and watched it convert food into products to be used in the body to maintain life and growth.

Somewhat later, another scientist, Rene de Reaumur, obtained a buzzard, which he made his pet. Together these two entered into a most interesting venture, the study of the mysteries of digestion. This particular buzzard was a most unusual bird. He had learned how to vomit unpalatable food. From the sponges and tubes which fell into this category, Doctor Reaumur was able to squeeze gastric juice and to study its properties.

Later the buzzard died and Reaumur was most unhappy. His pet, however, had led a most useful life, far more useful than is the lot of most buzzards, and had attained a sort of immortality. Later Doctor Reaumur wrote: "My buzzard died before a series of experiments which I had intended to perform upon it were completed. One of the first experiments that ought to be tried with this fluid would be to make it dissolve meat in a vessel just as it is dissolved in the living stomach."

The next explorer of the mysteries of digestion was Lazare Spallanzani who carred on his experiments in a more spectacular manner. He experimented on himself with bags and tubes filled with different kinds of foods, sometimes vomited and at other times pulled up by an attached string. He learned a great deal about how the stomach acted on different kinds of foods. Thus he learned that certain foods were more easily digested than others. Some foods, he learned, took a longer time to digest.

At about this time, in England, indefatigable John Hunter was making his interesting studies on the stomach, and a little later the chemist, Pruit, found that the stomach secreted an acid which was necessary for proper digestion.

* * *

None of these men, however, ever had an opportunity such as had Doctor Beaumont actually to observe the human stomach in action. So the young surgeon determined to make a thorough study of the processes of digestion. But there were no facilities to carry out this work in the rough northern country. He was the only man with scientific training for miles around. Accordingly, he applied to Washington for transfer to a more suitable station where his work could be done. In June, 1825, just three years after the accident to St. Martin, he was transferred to Port Niagara and with him, of course, went Alexis, in the capacity of manservant.

Niagara was a more densely populated country; it was nearer to civilization, also near to St. Martin's boyhood home. An overwhelming nostalgia must have seized the young man, for he decided that he wanted to go home to be among old friends and familiar surroundings and, without much ado, took his belongings and went.

The experiments were interrupted. Doctor Beaumont was sore in heart at the ingratitude of St. Martin. But what was he to do? The young trapper had vanished without a trace. Beaumont had performed but four experiments and began to mull over their results. He wrote them up and sent the article off for publication in the *Medical Recorder*. Incomplete as these experiments were, they did make clear that the gastric juices possessed some solvent properties. He proved that food in the human stomach was not merely macerated by the churning action of the stomach walls, but that it actually was acted upon by stomach juices and subjected to solvent action.

Before long Beaumont again received orders from Washington which sent him back to his old post, the frontier of the Michigan Territory. There was much to do there. The Indians had gone on the warpath, and there were wounds to heal and bodies to mend. For two years he was very busy and had almost forgotten about his experiments, when he learned that St. Martin had been located. St. Martin had married and was living with his wife and family in a small Canadian village. Fate had been unkind to the young trapper. He was "poor and miserable beyond description."

For two years Beaumont kept in touch with Alexis, trying to induce him to return. At last he was successful. Again Beaumont was transferred, this time to Fort Crawford at Prairie au Chien on the upper waters of the Mississippi. At great expense, in August, 1829, came St. Martin, his wife and two children, four years after his last experiment had been performed saw Beaumont at work again in his investigations on human digestion.

Beaumont had no elaborately equipped laboratory. His tools were pathetically few and simple: a thermometer, a sand bath and a few vials. But for eighteen months he worked with these crude appliances and learned a great deal, most of which was new. He proved that the solvent properties of the stomach juices probably were due to some chemical agent. He was receiving a meager salary, but out of it he managed to support St. Martin and his family. Alexis, however, was beginning to have grand ideas of his own importance. He realized that he was essential to the work that Beaumont was doing and, without much ceremony, announced that he and his family had to return to their home.

All this time Beaumont had been carrying out his work unaided. He determined to ask for a year's leave of absence so that he could take St. Martin abroad and seek the aid of chemists in solving the problems which he himself, because of his incomplete knowledge of chemistry, could not understand. But meanwhile Alexis had become insistent on returning home. There was nothing that Beaumont could do about it except to extract a promise that he would come back when required.

These experiments of Beaumont's, however, never were destined to come off smoothly. His request for a furlough was rejected for the very good reason that he was needed at home. The Indians again had broken out in rebellion. In addition, there was the cholera that had broken out among the trappers. For a year Beaumont had his hands full. Finally, in August, 1832, things became calmer and he was given a furlough with permission to go to Europe.

He got in touch with Alexis who, after some persuasion, rejoined him. The furlough was much too short to enable Beaumont to go to Europe, so he decided to remain at home and conduct his experiments there. Alexis remained with his benefactor for a year, as a servant. To satisfy his ego, Doctor Beaumont had Alexis enlisted as a sergeant to a detachment of orderlies in the War Department and thus, for five years, was assured of the cooperation of St. Martin, for he had taken special pains to be certain that the enlistment would run for that length of time.

Now Beaumont began to work in earnest. He wanted to learn what constituted taste, hunger and thirst.

He was among the first to learn that the sense of taste is very important to the process of digestion, and that the tastier the food the more it stimulated the flow of gastric juices and the more thoroughly it was digested. As for hunger, he learned that it was a sensation arising solely in the stomach. As soon as the stomach contained food the sensation was dissipated. But when it came to thirst, Alexis proved an unreliable subject. He loved his whisky and he loved it too well. He insisted emphatically that his craving for whisky was not satisfied when the liquor was poured through the hole in his stomach. He had to swallow it to get the burning taste of it.

Meanwhile, Doctor Beaumont had kept up his studies on the gastric juices. He was not much of a chemist, and had not the least idea how to

separate gastric juice into it various components to learn just what function each had to perform. He began to send samples of the gastric juices he had siphoned out of St. Martin's stomach to men who were more expert in chemical analysis.

To Dr. Robley Dunglison, Professor of Physiology at the University of Virginia, went a sample of gastric juice. But Doctor Dunglison was a physiologist, not a chemist. He did not know how to break down the mysterious juice into its component parts. Doctor Dunglison had quite a flattering opinion of himself and because he could not analyze the potent juice he did not hesitate to say that no one else could. There was no help from this source.

Doctor Beaumont then obtained permission to take a trip to New York City which, at that time, was the medical center of the United States. With him went Alexis, but while the doctors in New York could diagnose and treat disease in a very proficient way, they were not particularly clever as chemists. Beaumont packed himself and St. Martin off to New Haven to consult with Dr. Benjamin Silliman, who really knew chemistry but also knew his limitations. Doctor Silliman recommended Berzelius, of Stockholm.

Now Berzelius was a real chemist, a great chemist. He had taught chemists how to write in shorthand; he had invented chemical signs and symbols. Doctor Silliman thought Berzelius should be sent a bottle of gastric juice, "enough to fill a pint congress bottle, carefully marked, sealed, an capped with strong leather and twine and then encased in tin, with the lid soldered in, so that no one may open it."

It was a tedious job, collecting that pint of gastric juice. It required more than half-an-hour to collect it from the fasting stomach. Alexis was irritable. He was strongly of the opinion that to do this without whisky was asking too much. But it was finally done, and off to Berzelius in Stockholm went the pint of gastric juice.

Meanwhile the experiments went on. The problem now before Beaumont was to determine the difference in time between that required for normal digestion in the stomach and that required by the gastric juice in small glass bottles outside the stomach.

No word came from Berzelius. Doctor Beaumont remembered Professor Silliman's words, that analyzing the gastric juice would be a very difficult task, and he thought perhaps Berzelius too would fail. At any rate, he could no longer delay. He began to set down his observations on paper, and in time published them in a book.

This book became the foundation of practically all that we know about digestion today. He made observations such as these:

"That animal and farinaceous elements are more easy of digestion than vegetable."

"That digestion is facilitated by the division of food and the tenderness of the fiber and retarded by opposite qualities."

"That bulk as well as nutrient is necessary."

"That oily food is difficult of digestion though it contains a large proportion of nutrient principles."

"That solid food of a certain texture is easier of digestion than fluid."

"That the time ordinarily required for the disposal of a moderate meal is from three to three and a half hours."

Doctor Beaumont laid the foundation and soon others were to add, to build, to make our knowledge of digestion more complete than it ever had been. Within three years after Doctor Beaumont had begun his experiments with the properties of gastric juice, Dr. Theodor Schwann found that it was pepsin which was responsible for the action of this fluid. The chemical analysis of the juice had begun.

In France, a few years later, Dr. Claude Bernard showed that the juices of the pancreas emulsified fats and split starches into sugars to be absorbed into the blood. Then, in rapid succession, there were others: Pavlov, the greatest of Russian physiologists, who showed that the nerves played a very important part in digestion; Starling and Bayliss, the Englishmen, who found that the gastric juices contained a hormone, or chemical messenger, which had much to do with digestion; Cannon, the Harvard physiologist who, by means of x-rays, revealed the whole process of digestion in action.

But it was young Dr. William Beaumont, the military surgeon, who really started it all. His name is one of the greatest in medical history because he persisted in a search for an elusive something in spite of the lack of laboratories and instruments and in spite of discouragement heaped upon discouragement. He was the first of the great doctors to make clear the dynamics of digestion.

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## Unique Tribute

Many tributes have been paid Dean Edward J. Van Liere during the past few months in recognition of his dedicated service to the University and the people of West Virginia. One of the most unique was the manner in which he was honored by former students now attending the Medical College of Virginia in Richmond.

Early in June startled college officials observed that a "foreign" flag was flying atop the Medical College building. The banner of the Commonwealth had been replaced by the flag of the State of West Virginia. The prank was taken in stride and Dr. R. Blackwell Smith, MCV President, presented the flag to Dean Van Liere during commencement exercises several days later.

In the photograph above, Dean Van Liere is shown with three graduates of the two-year School of Medicine at the University who received M. D. degrees from MCV in June. Left to right, Dr. Kenneth B. Hatfield of Charleston, Dr. Lowell W. Schwab of Kingwood, and Dr. John D. Pitsenberger of Huntington.

**Dean Edward J. Van Liere**

# Dedicatory Ceremonies

## Basic Sciences Building—WVU Medical Center
## October 5, 1957

Dean Van Liere talks with Dr. William S. Middleton of Washington D. C., and former University President Irvin Stewart during the dedicatory ceremonies for the Basic Sciences Building. Doctor Middleton was the principal speaker for the occasion.

Two past presidents of the State Medical Association are shown with Dean Van Liere in the lobby of the Basic Sciences Building, Drs. Thomas L. Harris of Parkersburg and George F. Evans of Clarksburg.

Dignitaries who attended the dedicatory ceremonies were, left to right, Dr. J. Ben Robinson, former dean of the WVU School of Dentistry; Dr. Thomas J. Hill, professor emeritus of oral pathology, Western Reserve University; Dean Van Liere; former Governor Okey L. Patteson; Governor Cecil H. Underwood; Dr. William S. Middleton, Chief Medical Director, Veterans Administration; and Dr. Irvin Stewart, former president of West Virginia University.

## WVU School of Medicine
## 1916-1957

Erected at a cost of $18,000, this building on The University Campus housed the School of Medicine until it was razed in 1957 following completion of the Basic Sciences Building at the new Medical Center.

**1921-22**

Group picture of student body and faculty taken in front of old medical building during the first of Doctor Van Liere's 39 years as a member of the faculty. He is shown seated in the third row, third from right.

## Van Liere and Dodds

A recent photograph of Dean Van Liere and Gideon S. Dodds, Ph. D., Professor Emeritus of Histology and Embryology. Doctor Dodds joined the faculty in 1918.

**1935-36**

Doctor Van Liere succeeded Dr. John N. Simpson as Dean of the School of Medicine in 1935. Doctor Simpson's picture is included in this composite photograph of the student body and faculty. His photograph is just above that of Dean Van Liere in the center.

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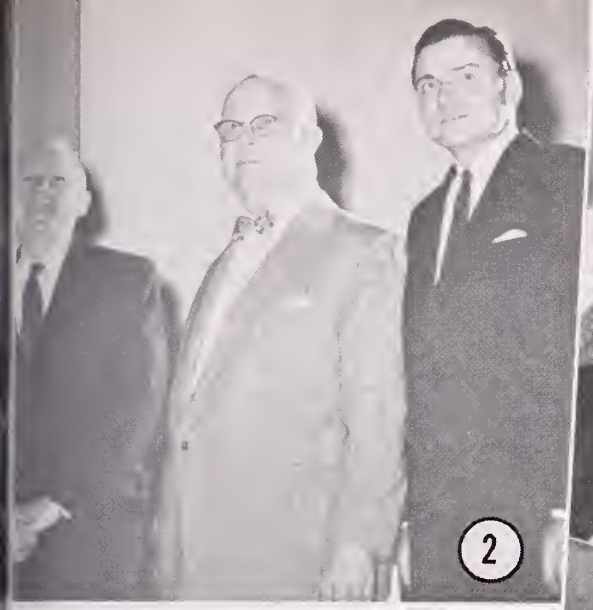

# Van Liere Day

**WVU School of Medicine**

**Medical Center**

**May 12, 1960**

(Identifying Notes on Page 363)

# The President's Page

## Progress and Pride

On Saturday, August 27, Dr. E. Vincent Askey, the great president of the American Medical Association, installed me as the 94th president of the West Virginia State Medical Association. I humbly accept this high honor which you have given me, and hope that you will work with me to make this a year of significant accomplishment. I pledge you my best efforts to the extent of my ability.

This space was reserved this month to pay special tribute to our "retiring" Dean of the West Virginia University School of Medicine, Dr. Edward J. Van Liere. But, as we go to press, Doctor Van Liere, with his usual dedication and willingness to serve has, at the request of University President Elvis J. Stahr, Jr., consented to continue to serve as Dean pending the appointment of a successor. This is typical of the man who has served for 25 years as Dean of our School of Medicine.

Scholar, teacher, author, counselor, friend, Doctor Van Liere joined the faculty of the School of Medicine in 1921 as Professor of Physiology. He was named Dean in 1935. It takes a special kind of man to be a Dean and Doctor Van Liere has met all the qualifications.

"Eddie" Van Liere never ceased to dream, plan and work for a four-year Medical School for West Virginia. On Wednesday, August 10, 1960, Dean Van Liere saw his dream come true with the acceptance of the first patients by the University Hospital, making it possible to admit the initial third-year medical class, a group of sixteen students who are candidates for the degree of Doctor of Medicine, class of 1962.

The West Virginia University Medical Alumni, in seeking a way to honor Dean Van Liere, felt assured that aiding medical students of the present and the future would be the closest thing to his heart. On May 12, 1960, at the Medical Center in Morgantown, at a program honoring Dean Van Liere, the Medical Alumni, through the West Virginia University Foundation, established a Student Loan Fund with a contribution of $10,000. Further contributions to this Fund are encouraged in order to assist our West Virginia boys and girls in obtaining a medical education. The Van Liere Fund is a medium through which we can all have a part in making medical education and medical care for all West Virginians a bright and shining star in the future of our State.

To the man who has written *A Doctor Enjoys Sherlock Holmes* (Vantage Press 1959), and such scientific articles as *Anoxia: Its Effect On The Body;* to the man who dreamed dreams and then worked to make his dreams come true; to the man who is never too busy to counsel or assist a student (such a man would shrug and say: "Elementary, my dear Watson"); to this man West Virginians owe a great debt of gratitude.

Doctor Van Liere, our heartfelt thanks.

John W. Hash

John W. Hash, M. D., President

# THE WEST VIRGINIA MEDICAL JOURNAL

*Official Organ of the West Virginia State Medical Association*

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.



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*Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.*

*Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.*


# EDITORIALS

## A FRUITFUL QUARTER OF A CENTURY

The close of the school year 1959-60 marked an important epoch in the life of Dr. Edward J. Van Liere—the completion of a quarter century of faithful and efficient service as Dean of the West Virginia University School of Medicine.

Scheduled to relinquish his administrative duties as of June 30, 1960, Doctor Van Liere has consented to continue to serve as Dean pending the appointment of a successor. Upon his retirement officially as head of the School of Medicine, he will continue to serve as Professor of Physiology.

In view of the great advances made in the School of Medicine during the tenure of Doctor Van Liere as Dean, his impending retirement should not pass without appropriate comment in these columns.

One of the significant features in the history of medical education in the State was the organization of the first two years of the medical curriculum by Dr. John N. Simpson in 1902, a plan which has continued through the intervening years. During the years of his service as Dean, Doctor Simpson did not give up the ambition that the school should expand to give the entire four years leading to the M. D. degree.

It is a great satisfaction to be able to record that at this time the school, under the leadership of Doctor Van Liere, has progressed far on the way to granting its first degrees in medicine and that this new program is developing on a scale far beyond the fondest hopes of the earlier years. With this in mind, it is eminently proper that we grant recognition to Doctor Van Liere for his important contribution to the attainment of this end.

Doctor Van Liere was born in Kenosha, Wisconsin, on October 30, 1896. After his elementary and secondary schooling he entered the University of Wisconsin from which he received the Bachelor of Science degree in 1915, and the Master of Arts in 1916. In 1920 he received the M. D. degree from Harvard, and in 1927 the Doctor of Philosophy degree in physiology from the University of Chicago. Although his education prepared him for the practice of medicine, he chose rather to devote his life to the work of teaching and research, and this in turn led to his important administrative work.

As to his earlier teaching experience, we note that from 1914 to 1916 he was an assistant in the Department of Biology of the University of Wisconsin, and in 1917-18 in the Department of Physiology of the University of Chicago. Upon the completion of his medical studies, he served for the school year 1920-21 as Professor of Physiology in the School of Medicine of the University of South Dakota (a two-year school). The following year (1921-22) he began his service

as Professor of Physiology and head of the Department in the School of Medicine of West Virginia University, the beginning of his 39 years of service there.

As head of the Department of Physiology, Doctor Van Liere not only maintained good teaching standards, but also developed an outstanding research program, in which he had the cooperation and support of a succession of capable members of the department staff. This led to the publication of many papers, both individual and joint, during the preparation of which the younger members of the staff received excellent training in the methods and ideals of research.

This research work was based upon experimental procedures on various laboratory animals. Much of the work of the department had to do with the reactions of the gastrointestinal tract and the circulatory system. As a development of this work, there emerged the extensive study of the effects of scarcity of oxygen, which brought forth many papers, including a monograph in 1942 by Doctor Van Liere entitled *Anoxia, Its Effect Upon the Body.* This work involved experimental studies, not only on laboratory animals, but also upon human volunteers, including members of the staff and the student body, making use of suitable equipment devised and prepared for that purpose.

It might also be mentioned that Doctor Van Liere, as a recreational activity, wrote a series of essays dealing with the medical aspects of the writings of A. Conan Doyle, concerning Sherlock Holmes and Doctor Watson. These have recently been published as a single volume.

The general administrative work of Doctor Van Liere began in 1935, when he was made chairman of a committee to suggest procedures which might enable the School to regain the approval of the accrediting agencies. It was then natural that he should be named Dean of the School, and to this position he brought a fortunate combination of training and experience.

On the one hand, he had a background of professional education in universities of high standing, and on the other a familiarity with and sympathetic understanding of the local situation, gained during the 14 years of his service as head of the Department of Physiology in the School of Medicine. The local tie was further strengthened by his marriage to Miss Alice Hartley, member of a Morgantown family. They have one married daughter and two grandchildren.

After Doctor Van Liere became Dean, he guided the School in the development of better standards and of a faculty organization which functioned well, even during the difficult years of World War II. One very fortunate development of those years was the arrangement with the Medical College of Virginia for the transfer to that institution, for the completion of their work, of a majority of the students of our then two-year School of Medicine.

Throughout the years of his deanship, he kept in mind the desirability of the development of a complete four-year program leading to the M.D. degree. For this there developed gradually an increasing desire throughout the State, in which physicians played a growing part.

As a result, the gratifying action of the Legislature in 1951 made provision for a complete medical curriculum, and also for Schools of Dentistry and Nursing. This was followed by the busy years of planning for the teaching programs, and the necessary building space. The new building was occupied in the fall of 1957, and the first degrees in Dentistry and in Medicine will soon be conferred.

This will be the culmination of a long cherished desire for a complete medical school. This had been foreshadowed by a continuous offering of courses which belong in the medical curriculum, even before the opening of the two-year program, beginning with the second year of the University, 1869-70.

It must be most gratifying to Doctor Van Liere that he has been privileged to be Dean of the School during the realization of this ambition and to know that he has had an important part in bringing about the desired end. It is truly a great pleasure for the editorial board of *The Journal* to express the thanks of the State to him for his service in this matter and to wish him well as he continues his activities as a member of the staff of the Department of Physiology.

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**OUR MEDICAL SCHOOL**

After many years of planning, plodding, pleading and pushing by the University and the West Virginia profession, our four-year School of Medicine is a *fait accompli,* and in this issue honoring our outgoing Dean Van Liere we want to urge the support of the University Medical Center by every practicing physician in the Mountain State. Running a medical school is a Herculean task at the best, and without the active support of the profession, may become infinitely more difficult. We have an up-to-the-minute plant and are developing a faculty second to none. Therefore, let us all put our shoulders to the wheel and give a big push.

Support means more than giving money or referring good teaching case material. It means encouraging prospective students to enter medicine; aiding and guiding them in pre-medicine and in their intramural years; affording them instruction and support in every way we can, and especially inculcating in them the dignity, the altruism, the ideals and the ethics of their chosen calling. It means contacting and educating the citizenry, and especially the members of the Legislature, as to the needs and costs of medical education and the needs of the State for medical care. It means the development of a sufficient number of scholarships to ensure that every capable West Virginia youth who wishes to enter medicine, but for lack of money cannot do so, may be tided over his financial shoals to a successful practice. Whether the financial aid comes as an outright donation or a loan fund matters little, but we cannot help but feel that the loan fund is more of a stimulant to the recipient to do good work.

All hail West Virginia University School of Medicine! May you help to build a better citizenry, a better profession and a better Mountain State.

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## NUTRITION AND ATHLETIC PERFORMANCE

Recently an authoritative article appeared in *Physiological Reviews* (Mayer, J. and B. Bullen, 40: 369-397, 1960) dealing with nutrition and athletic performance. This article is quite timely since the Olympic games have just been held.

The authors point out that the optimum diet for an athlete is not essentially different from that of any normal individual. They suggest that in general it is probably well for athletes to eat at least three meals a day; however, four or five lighter meals may be preferable if the sports practiced are exhausting. In the latter type sports there is evidence that performance is better maintained on a high carbohydrate diet than on a high fat diet. It is assumed in this connection that these diets have been consumed for several days prior to the event, with the meal immediately preceding being the most important. It is emphasized that the slightly increased efficiency on a high carbohydrate diet may make a difference in the final outcome of the contest.

Athletic performance does not seem to be influenced by wide variations of protein intake. Years ago it was held that a high protein intake was extremely beneficial in those sports which called for great stamina, such as rowing.

No positive evidence could be found that supplementation by water-soluble vitamins give additional beneficial results, nor could it be definitely substantiated that supplement of vitamin E and of wheat germ oil were of aid. The same was true for supplements such as gelatin or phosphates.

Alcohol should be generally avoided during training because of deleterious effects on coordination. Beverages containing caffeine, such as tea and coffee may, by decreasing awareness of fatigue, be of aid but it is not recommended that they be used in large amounts.

Unless sports are performed under unusually hot climatic conditions the use of salt above that generally contained in a meal appears unnecessary.

In summary, it seems that the principles underlying nutritional needs in athletes do not differ in any important essential from those applicable to all healthy people.

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## TOM HARRIS—FIFTEEN YEARS OF DEVOTED SERVICE

We don't recall having heard "renaissance" applied to West Virginia University and its remarkable progress since World War II, but the term is an apt one and it ties in with what we are about to say about one of its principal authors.

Dr. Thomas L. Harris of Parkersburg retired from the Board of Governors on June 30. As member and twice president of the Board, for fifteen years, three months, and twenty-eight days he had a front row seat from which he called many of the shots which led to a tremendous increase in the size of the physical plant, strengthened the teaching and research staff, greatly expanded the curriculum and services, and advanced the University from a position of dubiety in the minds of many of the state's citizens to one of universal confidence and popularity.

As one of West Virginia's foremost medical men and a past president of the State Medical Association, Doctor Harris brought to the Board, as it turned out, at a time when it was sorely needed, a wealth of experience and enlightened thinking in the planning of the Medical Center. Then too, in addition to his skill as a surgeon, he has been eminently successful in business and so was able to make a solid contribution to solution of the intricate problems of finance which many times were before the Board.

Doctor Harris was one of the original members of the new Board which came into being on March 3, 1945, following the installation of

a new State Administration. He continued when the Board was expanded to a nine-member body in 1947, served as Board president in 1949-50, and in 1951 was reappointed to the nine-year term which has just expired. His second term as president came during the past fiscal year.

The duties of Board members during these renaissance years have not been light. Some of the most time-consuming and difficult problems of the University's 93-year history have been crowded into this comparatively short span of time. His contemporaries will agree that none of their number worked harder, or even quite so hard, as Doctor Harris. Seldom, if ever, did he miss a Board meeting. He devoted hours and hours of his time, was ever generous of his material resources, and derived a genuine pleasure from "above and beyond the call of duty" activities in behalf of the University, which he first saw when he came to the campus as a freshman in 1906 from Hedgesville in his native Berkeley County.

A typical case in point occurred last fall when the Inauguration Committee was casting about for some means to finance the dinner planned for the eve of Elvis Stahr's inauguration as fourteenth President—an item hardly inconsequential in light of the 1,000 invitations contemplated.

Doctor Harris heard of the committee's problem and it was solved forthwith. He and his delightful wife, Betty, took over as host and hostess, and the dinner was a long-to-be-remembered success.

If ever a University alumnus deserved an emphatic and appreciative "well done" for his devotion, loyalty, and action on behalf of his alma mater, that man is Thomas Lewis Harris, M. D., Class of 1910.—*West Virginia University Alumni Magazine.*

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**BLUE SHIELD AND OUR NATIONAL LEADERSHIP**

The American Medical Association's recent declaration of renewed support for Blue Shield demonstrates that the national leadership of our profession recognizes the importance most of us in the state and county medical societies long ago attached to our support of local Plans. In its essence, the action of the AMA House of Delegates comprises an acknowledgment that medicine's own sponsored Blue Shield prepayment plans need all the support, understanding and guidance we can give them at every level of our professional activity.

Although each of the nation's 68 Blue Shield Plans was created by local or state societies to meet the particular needs of their own communities, the emergence of medical care as a national issue has compelled our profession to forge Blue Shield into an instrument capable of meeting and solving prepayment problems on a national scale.

In the past two decades, both management and labor have firmly embraced the principle of industry-wide bargaining. Employers, through merger and trade association action, and workers, through nationwide unions are increasingly concerning themselves with welfare and health programs extending from coast to coast and from border to border.

Whether we like it or not, the future of medical practice will be shaped by great continental interests and forces. If we wish to preserve the principles of free enterprise and individual integrity in American medicine, we must look to the national spokesmen of our profession for the same bold leadership and firm support of the Blue Shield concept that the leaders of the state and county sponsoring societies have given Blue Shield during all its tender years.

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### Internists—Quo Vadis

It is true that a few individuals spend a lot of time going from medical meeting to medical meeting with little real gain except a detailed knowledge of methods of transportation. On the other hand, the individual who is content to confine his educational pursuits to reading journals in his own arm chair loses perspective and tends to become a medical hermit.

One of the most valuable and most important and most rewarding experiences an internist can have is to know personally and be on speaking terms with other internists in other parts of the community, the state, the country, and even throughout the world. Attending medical meetings or visiting other clinics, if done in the right spirit at reasonably regular intervals, is well worth the time and expense involved.

Let the internist then have a true sense of humility; let him have an awareness that other internists have similar problems for which answers may have been found which can best be learned by personal contact; let the internist have an interest in broadening his medical background. If he will also adhere to the concept of hard study and discipline in the art and science of medicine, he will truly approach fulfillment of his professional capabilities and really excel and exceed his teachers. Should such a course prevail, the story of Internal Medicine in ten, fifty or one hundred years will indeed be interesting to record.—Lewis B. Flinn, M. D., in Delaware Medical Journal.

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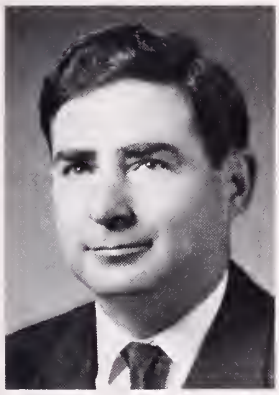
### Labor of Love

Experience teaches that love of flowers and vegetables is not enough to make a man a good gardener. He must also hate weeds.—Eugene P. Bertin.

# GENERAL NEWS

## 13th Annual Rural Health Conference At Jackson's Mill, Oct. 6

The 13th Annual Rural Health Conference will be held at Jackson's Mill on Thursday, October 6. The theme for the meeting, which is expected to attract more than 250 representatives of farm groups and others interested in rural health, will be "Meeting Community Health Challenges."



W. Wyan Washburn, M. D.

The conference is sponsored annually by the West Virginia State Medical Association in cooperation with the Agricultural Extension Division of West Virginia University, the West Virginia Home Demonstration Council, the State Department of Health, the West Virginia Farm Bureau, and the West Virginia Congress of Agriculture.

Dr. Earl L. Fisher of Gassaway, who is in charge of the program for this year's conference, will call the meeting to order in the Assembly Hall promptly at 10:00 A. M. The invocation will be given by Dr. Stanley H. Martin, President of West Virginia Wesleyan College.

### Keynote Address by Dr. W. Wyan Washburn

Following opening remarks by Doctor Fisher, the keynote address will be delivered by Dr. W. Wyan Washburn of Boiling Springs, North Carolina, member of the American Medical Association's Council on Rural Health. His subject will be "Health is Wealth."

### Discussion Groups

Following Doctor Washburn's address, those present will separate into groups for discussion of topics concerned with rural health. The topics, with the names of discussion leaders, are as follows:

First group, "Cost and Availability of Medical Care in Rural Areas," George T. Hoylman, M. D., Gassaway;

Second, "Conservation and Health," Clark K. Sleeth, M. D., Morgantown, assistant to the dean, WVU School of Medicine;

Third, "Health Mobilization in Rural Areas," Samuel J. Hawkins, program consultant in health mobilization, State Department of Health; and

Fourth, "Mental Attitudes Toward Health," Rev. Aldred Wallace, pastor of the Wesley Methodist Church, Morgantown.

Persons thoroughly familiar with the subjects to be discussed will serve as resource representatives for the groups.

### Afternoon Session

Dr. John W. Hash of Charleston, President of the West Virginia State Medical Association, will deliver the address of welcome at the opening of the afternoon session which will begin at 1:15 o'clock.

Following his address, spokesmen from each of the four morning workshops will present summaries of the material discussed before their groups. The spokesmen will be as follows:

J. C. Huffman, M. D., of Buckhannon, immediate past president of the State Medical Association ("Cost and Availability of Medical Care in Rural Areas"); Clark K. Sleeth, M. D., ("Conservation and Health"); Samuel J. Hawkins ("Health Mobilization in Rural Areas"); and George F. Evans, M. D., of Clarksburg, former president of the State Medical Association ("Mental Attitudes Toward Health").

There will be a question and answer period, with full audience participation, following the remarks of each speaker.

### Luncheon in Mount Vernon Dining Hall

Luncheon will be served in the Mount Vernon Dining Hall at 12:15 P. M., with the West Virginia State Medical Association as host.

## Convention Story Will Appear In October Journal

The 93rd Annual Meeting of the West Virginia State Medical Association is being held at The Greenbrier in White Sulphur Springs as this issue of *The Journal* goes to press.

The full convention story, including information concerning new officers of both the State Medical Association and Auxiliary, as well as heads of sections and affiliated societies and associations, will be carried in the October issue.

The conference is open to members of all interested groups, and a formal invitation to attend the one-day meeting is being extended to members of local farm bureaus, home demonstration councils, agricultural extension workers, and personnel of local health departments.

## Weekly Grand Rounds Arranged By WVU School of Medicine

Weekly "Grand Rounds" of the Department of Surgery of the WVU School of Medicine will be held each Saturday morning at nine o'clock in Room 4080 of the Basic Sciences Building in Morgantown, beginning September 3, 1960.

In announcing the inauguration of the program, Dr. Bernard Zimmermann, professor and chairman of the Department, said that it is planned to have a discussion or clinical demonstration weekly by a member of the staff, or in some instances by an outside speaker. In addition, gross microscopic specimens will be reviewed by a representative of the pathology department.

Doctor Zimmermann also said that it is planned to show interesting x-ray films of current surgical cases.

All physicians interested in surgery are invited to attend and participate in the conferences, and it will be the desire of faculty members in charge to make them as stimulating as possible.

Doctor Zimmermann has said that notice of the program and information concerning the topic to be discussed will be mailed the week prior to each Saturday conference.

## Georgia Warm Springs Foundation Possible Rehabilitation Center

A special grant of $26,228 has been made by the U. S. Department of Health, Education and Welfare to the Georgia Warm Springs Foundation.

In announcing the award, Miss Mary Switzer, director of the Department's Office of Vocational Rehabilitation, said that the grant is for the purpose of continuing a study to determine the possibility of developing the Georgia Warm Springs Foundation into a regional comprehensive rehabilitation center "to serve the physically handicapped in the seven southeastern states."

Under the grant, Dr. Robert L. Bennett, executive director of the Foundation, will direct an evaluation of services presently available to the physically handicapped at the Warm Springs Center. He will be assisted by George C. Beckmann, Jr., Administrator of medical operations.

## Dr. C. B. Pride Reappointed to MLB

Dr. Cecil Ben Pride of Morgantown has been reappointed by Governor Cecil H. Underwood as a member of the Medical Licensing Board for the five-year term ending June 30, 1965. He has been a member of the MLB since 1949.

## Regional Meeting of Cancer Society At The Greenbrier, Sept. 10-11

The annual meeting of Region II of the American Cancer Society will be held at The Greenbrier in White Sulphur Springs, September 10-11.

Dr. Chauncey B. Wright of Huntington, president of the West Virginia Division of the ACS, will preside during the two-day session, which will be attended by professional and lay committee volunteer leaders from the divisions of Delaware, District of Columbia, Maryland, New Jersey, Ohio, Pennsylvania, Philadelphia, and West Virginia.

The regional meeting is an annual affair at which an opportunity is provided for representatives of the various divisions to discuss professional information, public education, services, fund-raising, and research activities of the ACS. The Region's director members to the National Board will be nominated during the meeting.

The opening session will be called to order on Saturday morning, September 10, at ten o'clock, with welcoming addresses by Doctor Wright, and Charles Lively, executive secretary of the West Virginia State Medical Association.

Formal addresses will be presented at the morning session by Lane W. Adams, executive vice president of the ACS, whose subject will be "A Look to the Future," and by N. H. Dyer, M. D., state director of health, and Dr. B. Aubrey Schneider, assistant director, statistical research, ACS, who will discuss "Central Cancer Registries."

The Saturday afternoon session will feature panel discussions by three groups as follows:

Director Divisional Representation—Samuel P. Harbison, M. D., Professional Delegate Member, Pennsylvania Division; Wylie W. Barrow, Lay Delegate Member, District of Columbia Division; and Lane W. Adams, Executive Vice President of the American Cancer Society.

Combined Health Solicitation in Trades and Industry—C. Bernard Brack, M. D., Board Member, Maryland Division, and Jess W. Speidel, II, Vice President, Crusade Department, American Cancer Society.

Division Success Stories—Representatives from Delaware, District of Columbia, Maryland, New Jersey, Ohio, Pennsylvania, Philadelphia, and West Virginia.

There will be a reception in the Fillmore-Van Buren Room at six o'clock on Saturday evening, with the West Virginia Division, ACS, as host.

The session on Sunday will be in the nature of a business meeting for the purpose of nominating the Region's director members to the National Board, receiving committee reports, adopting resolutions, and fixing the time and place for next year's meeting.

Doctor Wright of Huntington and Mr. J. Ross Hunter, Jr., of Charleston, are delegate members of the West Virginia Division of the ACS.

## Drs. Van Liere and Stickney Write Chapter for New Book

The latest contribution of Dr. E. J. Van Liere to the field of medical literature is the joint authorship with Dr. J. Clifford Stickney of a chapter (Chapter 12) in a new Harper book, "Science and Medicine of Exercise and Sports," edited by Dr. Warren R. Johnson.

The title of the chapter written by Drs. Van Liere and Stickney is "The Effects of Exercise Upon the Function of the Gastrointestinal Tract."

An interesting review of the book itself, written by John B. Harley, M. D., of the faculty of the School of Medicine, will be found in the Book Review Section of this issue of *The Journal.*

The following abstract of the Van Liere-Stickney chapter has been prepared for *The Journal* by Theodore Brown, research assistant, department of physiology of the School of Medicine:


### Abstract

The authors have compiled a complete and systematic review of the literature pertaining to the effects of exercise on the gastrointestinal tract and its associated organs. An effort is made to resolve some long-established problems in the light of new experimental evidence.

The study is divided into two phases: first, changes in the tone and/or motility of the gastrointestinal tract; and second, changes in rate and amount of secretion from the tract and associated organs due to effect of exercise on (a) reflex action, (b) chemical substances which are increased or synthesized *de novo*, (c) splanchnic blood flow, and (d) psychic factors that result from exercise stress.

As a result of this study, several general conclusions may be drawn. Mild exercise has little or no effect on either motility or secretion of the gastrointestinal tract although in some subjects it causes slight stimulation of each.

Donaldson found an increase in wet weight of the submaxillary salivary glands in rats provided with revolving drums for voluntary running. It is not known if the enlargement is due directly to exercise or to the secondary effects of increased appetite and food consumption. In contrast, the same investigator found a slight reduction in the wet weight of liver in chronically exercised animals although exercise does not affect the power of regeneration.

Violent exercise inhibits both tone and digestive motility of the stomach, and is followed by a period of hyperactivity. Its effect on the small and large intestines is relatively unknown although one study shows an increase in the propulsive motility of the small intestines as a result of chronic exercise. Gastric secretion is inhibited, and it was determined by using a dog with both esophageal and gastric fistules that the inhibition due to exercise acts chiefly on reflex secretion. Inhibition of the humoral phase of gastric secretion by exercise is demonstrated by the dog with the Heidenhain type gastric pouch in which the vagus nerves are severed. This inhibition is mediated through some chemical substance, for a blood transfusion from an exercised animal will result in an inhibition in that animal. The nature of this substance as well as its sites of production are unknown. In the liver, exercise has been concluded by Frerichs to reduce digestive hyperemia and it has been shown by Ranke that less bile is produced during muscle tetany.

Difficulties in estimating splanchnic blood flow arise from errors caused not only by technique but by trauma produced by indwelling catheters, and it is virtually impossible to evaluate the data obtained. The problem is further increased by the fact that most work is on fasting subjects. In summary, it appears that in the fasting human subject the splanchnic area contributes storage blood during exercise and in the process suffers a local ischemia. The presence of a meal permits this region to compete with skeletal muscles, and as a consequence blood flow remains adequate for local needs.

In conclusion, exercise when moderate permits the digestive tract to function normally. Severe exercise following a meal may produce alterations in the digestive function such that the rate of doing work may be limited, but due to a large margin of safety no permanent changes to either digestive or voluntary muscle function result.


## Van Liere Pictorial

(See Pages 354-355)

**(1) Dean and Mrs. Van Liere greet a few of the more than 400 persons who attended the special program honoring Doctor Van Liere at the Medical Center in May.**

**(2) Doctor Van Liere's portrait was presented to the University during the ceremony. Shown with the Dean are Dr. Thomas L. Harris of Parkersburg and University President Elvis J. Stahr, Jr.**

**(3) A large number of West Virginia physicians attended the special program, including Drs. Newman H. Newhouse, G. Ralph Maxwell, Pat A. Tuckwiller, J. C. Huffman, John T. Chambers and John L. Crites.**

**(4) Guest speakers were Dr. David B. Dill (left) and Dr. Carl J. Wiggers (second from left). They are shown talking with Drs. Kenneth E. Penrod and Carl E. Johnson.**

**(5) President Stahr accepts check from Dr. John W. Hash as a contribution to the E. J. Van Liere Medical Student Loan Fund.**

**(6) Dignitaries at the ceremony included (left to right) Dr. Carl E. Johnson, Mr. Francis A. Goad, second-year medical student, Dr. Thomas L. Harris, Dr. J. C. Huffman, Dr. Carl J. Wiggers, Dean Van Liere, Dr. David B. Dill, Dr. Kenneth E. Penrod, and Dr. John W. Hash.**

**(7) Dean Van Liere and Dr. Thomas L. Harris.**

**(8) Larry Hemmings of Charleston (seated in first row at right) was among the medical students in attendance. He was the recipient of the State Medical Association's first four-year scholarship to the School of Medicine.**

## Dr. N. W. Fugo Accepts Appointment At WVU School of Medicine

Dr. Nicholas W. Fugo of Chicago, Illinois, has been appointed Professor and Chairman of the Department of Obstetrics and Gynecology at the West Virginia University School of Medicine. The appointment of Doctor Fugo was announced in August by President Elvis J. Stahr, Jr.

Doctor Fugo, who has served as a member of the faculty at the University of Chicago School of Medicine since 1946, will assume his duties at the Medical Center at the beginning of the fall semester.

A native of Syracuse, New York, Doctor Fugo was graduated from Syracuse University. He received his M. D. degree from the University of Chicago in 1950,

Nicholas W. Fugo, M. D.

and also received a Ph.D. degree in pharmacology from the State University of Iowa.

Doctor Fugo's main field of interest is the endocrinology of reproduction. He is recognized as both an educator and a research scientist and is the author or co-author of more than a score of articles and papers which have been published in professional journals. He has also had extensive training in the biological field, including World War II naval service as an aviation physiologist and as an instructor in pharmacology at Iowa State and the University of Chicago.

He has also served as a member of the staff at Chicago Lying-In Hospital and is certified by the American Board of Obstetrics and Gynecology. He is a member of the Society for Experimental Biology and Medicine, Society for Clinical Research, Society for Experimental Pharmacology and Therapeutics, the American Society for Study of Sterility and the American College of Obstetrics and Gynecology. He is a member of the Illinois State Medical Association and the American Medical Association.

## Film on Highlights of AMA Meeting Available for Showings

Medifilm Report II, featuring highlights of the 109th Annual Meeting of the American Medical Association in Miami Beach, is now available for showings before medical and allied groups.

Produced by Schering Corporation, in cooperation with the AMA Department of Medical Motion Pictures and Television, the 33-minute black and white film features scientific exhibits, lectures and panel discussions. The narrator is Dr. Ralph Jones, Jr., professor of medicine at the University of Miami School of Medicine.

Interested groups may obtain a copy of the film by writing to the AMA Department of Medical Motion Pictures and Television, 535 North Dearborn Street, Chicago 10, Illinois, or to the Audio-Visual Department, Schering Corporation, Union, New Jersey.


### Acknowledgment

The Publication Committee acknowledges with deep gratitude the splendid cooperation received from various individuals and groups in connection with the preparation of material for this issue of *The Journal*, which is dedicated to Dean Edward J. Van Liere.

We are especially indebted to the many colleagues of Dean Van Liere at the West Virginia University School of Medicine and to the Bureau of Information at the University.


## Dedication of University Hospital Set for October 8

The University Hospital at Morgantown will be formally dedicated on October 8. Speakers for the occasion will be Governor Cecil H. Underwood, University President Elvis J. Stahr, Jr., former University President Irvin Stewart, former Governor Okey L. Patteson and Dr. James A. Shannon, director of the National Institutes of Health, U. S. Public Health Service.

Governor Underwood will represent the state government and the people of West Virginia. President Stahr will speak on behalf of the University, and former President Stewart will speak as the institution's chief executive during the period when the Medical Center was planned and construction begun.

Former Governor Patteson will confine his remarks to a review of the initial planning phases and the beginning of construction of the Center, which was located in Morgantown as the result of a decision made by him.

Under Doctor Shannon's direction, the National Institutes of Health supports research throughout the country in all fields of the health sciences. It is the source of many grants supporting research projects by members of the University faculty.

## Second Governor's Conference on Aging In Charleston, Sept. 1-2

The Second Governor's Conference on Aging, which will be held at Morris Harvey College in Charleston, September 1-2, will be in the nature of an open Citizen's Forum in which an individual will have an opportunity to play an important role in expressing his ideas on the subject of aging.

F. Duane Hill of Charleston, Director of the Department of Employment Security, who is the Conference Director, has said it is expected that the recommendations that will be made during the meeting will be presented to the White House Conference in 1961.

The Conference will be sponsored by Governor Underwood, The West Virginia Commission on Problems of the Aging, and the West Virginia Department of Employment Security in cooperation with the U. S. Department of Health, Education and Welfare.

The first Governor's Conference on Aging was held in September, 1959, for the purpose of "arousing statewide interest in the problems of West Virginia's growing population of older citizens," and further for making plans for the White House Conference in 1961.

The theme of the 1960 Governor's Conference will be "Aging With A Future—Every Citizen's Concern." This same theme has been adopted for the 1961 White House Conference.

### Governor Underwood and Dr. Klumpp To Speak

The first general session will be held in the auditorium at Morris Harvey College, beginning at 10 o'clock on Thursday morning, September 1. The address of welcome will be delivered by J. Floyd Harrison of Wayne, chairman of the West Virginia Commission on Problems of the Aging.

Governor Cecil H. Underwood will be the first speaker at the formal session. His subject will be "Our Responsibility to our Senior Citizens."

Theodore G. Klumpp, M. D., President of Winthrop Laboratories, New York City, and member of the American Medical Association's Committee on Aging, will be the second speaker on the program. His topic will be "New Horizons for the Aging."

### Conference Luncheon on Thursday

The Conference luncheon, which will be held in the college cafeteria, will be a subscription affair and advance reservations are required. The cost will be $2.50 per person.

### Eight Discussion Groups

The afternoon session will get under way at one-thirty, with the "charge" to the discussion groups by Dr. B. C. Harrington, Chairman of the Education Department of Davis and Elkins College.

Mr. Hill said that the Conference will be divided into eight separate discussion groups, meeting concurrently and organized within the areas of (1) Income Maintenance; (2) Health and Mental Health; (3) Employment and Vocational Rehabilitation; (4) Education, Recreation, Library Services and Related Fields; (5) Housing (including Nursing Homes); (6) Social Services; (7) Religious Organizations in the Life of the Aging; and, (8) State and Local Community Organization and Leadership Development.

Arrangements will be made for three sessions for each group, the first for the purpose of reviewing and discussing the state survey; the second fact finding and evaluation; and the third, conclusions and recommendations.

Discussion groups will function during the afternoon on Thursday, and on Friday morning.

The final general session will get under way in the auditorium at 11:30 on Friday morning, with Marshall Buckalew, vice president of Morris Harvey serving as chairman.

### Recommendations To Be Acted Upon on Friday

Dr. Thompson R. Fulton, Professor of Social Work at West Virginia University and chairman of the Commission's steering committee, will be in charge of the submission of reports by leaders of discussion groups, in which final recommendations will be made and acted upon. It is expected that the conference will adjourn not later than one o'clock on Friday afternoon.

### Conference Personnel

In addition to the chairman, J. Floyd Harrison of Wayne, the Governor's Commission on Problems of the Aging is composed of C. Royall Kessel, M. D. of Ripley, vice chairman, Mrs. Alice VanLandingham of Morgantown, secretary, Mrs. G. Thomas Evans of Fairmont, E. B. Saunders of Clarksburg, Dr. B. C. Harrington of Elkins, Dr. Thompson R. Fulton of Morgantown and Harry Flesher of Huntington.

### New Address?

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston 24, West Virginia.

## Congress on Industrial Health In Charlotte, Oct. 10-12

The 20th Annual Congress on Industrial Health, sponsored by the AMA Council on Occupational Health, will be held at the Hotel Charlotte in Charlotte, North Carolina, October 10-12.

Dr. William P. Shepard of New York City, Chairman of the AMA Committee, will preside at the three-day meeting which will feature panel discussions and addresses by authorities in the field of occupational health.

Dr. E. Vincent Askey of Los Angeles, California, President of the American Medical Association, will be the principal speaker at the banquet which will be held on Tuesday evening, October 11.

Physicians interested in attending this meeting may obtain additional information by writing to 20th Annual Congress on Industrial Health, 526 Charlottetown Mall, Charlotte 4, North Carolina.

## Cancer Research Chair Set Up at WVU By Charleston Foundation

A special chair for research in the field of cancer and tumors has been established at the Medical Center of West Virginia University as the result of a $16,000 gift from the Charleston Foundation for Medical Research and Education. Announcement of the gift was made jointly early in August by University President Elvis J. Stahr, Jr., and G. B. Capito, M. D., Charleston physician who established the Foundation in 1959.

The new chair, which will be known as the "Charleston Foundation for Research Chair," will be filled by an outstanding scientist whose duties will include internal coordination of cancer and tumor research at the Medical Center, marshaling support for additional research projects, and organizing symposia and seminars in addition to conducting his own research program.

Funds contributed by the Charleston organization will be supplemented by the University to the extent necessary to attract the best possible man for the position.

President Stahr has announced that the Foundation plans to contribute $10,000 annually toward the maintenance of the chair, the establishment of which was unanimously approved by the Foundation's board of directors.

Doctor Capito is a native Charlestonian and has spent his entire professional life in that city. He served as president and medical director of the Kanawha Valley Hospital for several years prior to 1959, when he established the Charleston Foundation. He is also chairman of the non-profit Kanawha Valley Hospital Cancer and Tumor Clinic.

Besides Doctor Capito, the directors of the Foundation are Mason Crickard, chairman of the board of The Charleston National Bank; Thomas B. Jackson and Beverley Broun, both Charleston lawyers; John M. Capito, vice president, United Producing Company; Charles L. Capito, assistant administrator, Kanawha Valley Memorial Hospital; Norman S. Fitzhugh, certified public accountant; and Charles C. Wise, Jr., Charleston attorney, who was recently appointed by Governor Cecil H. Underwood as a member of the University Board of Governors.

## Regional Rural Health Meeting In Atlanta, October 7-8

The Council on Rural Health of the American Medical Association has announced that a Regional Conference on Rural Health will be held at the Dinkler Plaza Hotel in Atlanta, Georgia, October 7-8. Physicians and farm group representatives from 11 Southeastern states are expected to attend the two-day meeting.

Dr. Julian P. Price of Florence, South Carolina, Chairman of the AMA Board of Trustees, will be the principal speaker. Theme of the Conference is "Joining Hands for Community Health."

Further information may be obtained by writing to the AMA Council on Rural Health, 535 North Dearborn Street, Chicago, 10, Illinois.

### Relocations

Dr. Theodore H. Boysen, III, former Director of the State Department of Health's Division of Maternal and Child Health, has moved to Rock Springs, Wyoming, where he is engaged in the practice of his specialty of obstetrics and gynecology. He has offices at 215 Broadway in that city.

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Dr. William R. Moore, II, of Moundsville, has accepted a residency in obstetrics and gynecology at the Charity Hospital in New Orleans. He entered upon his new work in that city on July 1.

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Dr. William D. Irvine, formerly of Lewisburg, who has completed a residency in internal medicine at Beckley Memorial Hospital, has located at Laurens, South Carolina, for the practice of his specialty. His offices are at 426 West Main Street in that city.

* * * *

Dr. C. T. Clark, who has engaged in general practice at Iaeger for the past 27 years, has accepted appointment as a member of the staff of the Fayette County (Kentucky) Health Department, with headquarters at Lexington. Doctor Clark has moved with his family to Lexington and his address there is 1200 Colonial Drive.

* * * *

Dr. John J. Schaefer, who recently completed his residency training in thoracic surgery at Mt. Morris Tuberculosis Hospital in Mt. Morris, New York, is now associated with Dr. Morris H. O'Dell of Charleston. They have offices at 1205 Quarrier St.

## W. Va. Heart Association Schedules Annual Meeting in Parkersburg

The annual meeting of the West Virginia Heart Association will be held at the Chancellor Hotel in Parkersburg on September 16, with the president, Dr. J. J. Jenkins, Jr. of Fairmont presiding.

The general subject for discussion will be "Cardiac and Industry," and the following is the list of speakers who will appear on the program:

A. Carlton Ernstene, M. D., president, American Heart Association, Cleveland; Herman K. Hellerstein, M. D., Cleveland Clinic; David Colfand, M. D., assistant professor of cardiology, University of Pennsylvania, Philadelphia; Eugene J. Ryan, plant medical director, the E. I. du Pont de Nemours & Co., Belle; R. J. Sexton, M. D., plant medical director, Union Carbide Chemicals Co., Institute; and Mr. F. Ray Power, director, State Vocational Rehabilitation Division, Charleston.

Doctor Ernstene will be the guest speaker at the dinner in the evening. His subject will be, "AHA and the Road Ahead."

Further information concerning the meeting may be obtained by writing Mr. Frederick S. Kelley, Executive Director, West Virginia Heart Association, 1906 Washington Street, E., Charleston.

## State Conference on the Handicapped At Marshall College, Sept. 28-29

The Third West Virginia Conference on the Handicapped, sponsored by the Nemours Foundation, will be held at Marshall College in Huntington, September 28-29. The theme will be "Emotional and Psychological Aspects of the Handicapped."

A planning session for group leaders, analysts and recorders will be held Wednesday morning, September 28, at 9:30 o'clock, and the first general session will follow in the auditorium of "Old Main" at the College.

The address of welcome will be delivered by Dr. Stewart H. Smith, Marshall president, and introductory remarks will follow by Dr. A. R. Shands of Wilmington, Delaware, medical director of the E. I. Du Pont Institute of The Nemours Foundation.

Dr. Lee Myerson, program director of Somatopsychology Department of Psychology, University of Houston, will deliver the keynote address, his subject being "The Nature of the Emotional and Psychological Aspects of the Handicapped."

The Wednesday afternoon program will feature an address by Dr. Robert J. Havighurst, professor of education at the University of Chicago. His subject will be "The Emotional and Psychological Problems of the Handicapped as They Relate to the Educational Needs."

Group meetings have been arranged for the two-hour period following Doctor Havighurst's address. Each group will have a leader, an analyst, a recorder and one or more resource persons.

The annual banquet will be held on Wednesday evening, and the guest speaker will be Dr. Stewart A. Smith.

Group meetings will be concluded on Thursday morning, September 29, and luncheon will be served at noon. The guest speaker will be Dr. Salvatore Di Michael of New York City, regional representative of the U. S. Office of Vocational Rehabilitation. His subject will be "Vocational Rehabilitation Needs of the Handicapped Persons in Terms of Emotional and Psychological Problems."

Mr. F. Ray Power of Charleston, director of the Division of Vocational Rehabilitation, State Department of Health, is chairman of the state planning committee, and Mr. D. Banks Wilburn of Huntington, chairman of the local planning committee.

## Annual Meeting, SE Allergy Assn. At Atlanta, Oct. 21-22

The Annual Meeting of the Southeastern Allergy Association will be held at the Atlanta Biltmore Hotel in Atlanta, Georgia, October 21-22. Dr. Susan Dees, of Duke Medical College, will be in charge of the program, and a cordial invitation has been extended to all interested physicians to attend the two-day meeting.

Full information concerning the program may be obtained by writing to Dr. Katherine Baylis MacInnis, Secretary, Southeastern Allergy Association, 808 Albion Road, Columbia, South Carolina.

## Dr. Harry F. Cooper Presented With ACCP Fellowship

Dr. M. J. Flipse of Miami, Florida, was elected President of the American College of Chest Physicians at the 26th Annual Meeting held in Miami Beach immediately preceding the AMA Convention in that city in June. Other officers were elected as follows:

President elect, Dr. Hollis E. Johnson, Nashville, Tennessee; first vice president, Dr. John F. Briggs, St. Paul, Minnesota; second vice president, Dr. Charles K. Petter, Waukegan, Illinois; treasurer, Dr. Albert H. Andrews, Chicago, Illinois; and assistant treasurer, Dr. William E. Adams, Chicago, Illinois.

Mr. Murray Kornfeld of Chicago is the executive director of the College.

Dr. Harry F. Cooper of Beckley was among the 170 members who were presented with Fellowship certificates during the meeting.

The 27th annual meeting of the college will be held in New York City, June 22-26, 1961.

### Need a New Auto Emblem?

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

### New Association Members

Dr. H. Summers Harrison, 912 Lee Street, Summersville (Central West Virginia). Doctor Harrison, a native of Fenwick, West Virginia, was graduated from West Virginia University and received his M. D. degree in 1958 from the Medical College of Virginia. He interned at Charleston General Hospital, 1958-59, and was licensed to practice in West Virginia in 1959.

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Dr. Malcolm G. S. MacAulay, 108 Greenbrier Court, Beckley (Raleigh). Doctor MacAulay was born in East Angus, Quebec, Canada, and received his M. D. degree in 1949 from the McGill University Faculty of Medicine in Montreal, Canada. He interned at St. Luke's Hospital in Newburgh, New York, 1949-50, and served a residency at Walter Reed General Hospital 1953-56. He served for six years with the Medical Corps of the United States Army and was released in 1959 with the rank of Major. His specialty is psychiatry.

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Dr. Herbert W. Rannels, Man Memorial Hospital, Man (Logan). Doctor Rannels, a native of Marietta, Pennsylvania, received his M. D. degree in 1938 from the University of Pennsylvania School of Medicine. He interned at Chestnut Hill Hospital in Philadelphia, 1938-39, and served residencies at Kensington Hospital and the New York Postgraduate Medical School, 1939-41. He served as a Lt. (SG) in the Medical Corps of the United States Navy and formerly practiced his specialty of obstetrics and gynecology in New York City.

## Dr. Peter P. Ladewig To Speak At Seminar in Richmond

A Seminar on Kidney Disease, sponsored jointly by the Southeastern Region of the College of American Pathologists and the Virginia Society of Pathologists, will be held at the John Marshall Hotel in Richmond, Virginia, November 25-26.

Dr. Peter P. Ladewig of Charleston will be among the guest speakers at the two-day meeting. Other participants will include Drs. Stanley M. Kurtz, Henry D. McIntosh, George Margolis, Conrad L. Pirani, David E. Smith and Max Wachstein.

One of the features of the meeting will be a slide seminar which will be conducted by Drs. Paul Kimmelstiel and Solomon Papper. Slide sets for the seminar may be purchased in advance for $15.

Dr. Frank C. Coleman, president of the College of American Pathologists, will be the speaker at the banquet which will be held in connection with the meeting.

Further information concerning the meeting may be obtained by writing to Geoffrey T. Mann, M. D., LL.B., Professor of Forensic Pathology, P. O. Box 41, Medical College of Virginia, Richmond 19, Virginia.

## ACP Sponsors Postgraduate Course In New York, Oct. 10-14

A Postgraduate Course on "Cancer and the Internist —1960 Concepts," sponsored by the American College of Physicians, will be held at the Memorial Sloan-Kettering Cancer Center in New York City, October 10-14.

Dr. Rulon W. Rawson, the director, has announced that the course is designed to emphasize the problems of internal medicine as they are encountered in the patient with cancer, and the emerging role of the internist in the care and management of these patients. The course will be in the nature of a series of panel discussions to consider these problems in depth. Question and answer periods will be held at the conclusion of each morning and afternoon session.

Registration fee for the five-day meeting is $60.00 for members of the College, and $80.00 for nonmembers. Further information may be obtained by writing to the American College of Physicians, 4200 Pine Street, Philadelphia 4, Pennsylvania.

## Maryland GP Academy To Meet In Baltimore, Oct. 8-9

The 12th Annual Scientific Assembly of the Maryland Academy of General Practice will be held at the Southern Hotel in Baltimore, October 8-9, 1960.

There will be four scientific sessions, two on Saturday and two on Sunday. The annual banquet is scheduled for Saturday evening.

Full information concerning the meeting may be obtained by writing Mr. William J. Wiscott, Executive Secretary, 3722 Greenmount Avenue, Baltimore 18, Md.

## PG Medical Seminar Cruise Planned By Duke U. School of Medicine

The Duke University School of Medicine has invited West Virginia physicians to participate in a Postgraduate Medical Seminar Cruise to the West Indies aboard the transatlantic liner and cruise ship, the Kungsholm. The ship will sail from New York on November 9, will visit the Virgin Islands and Puerto Rico, and will return to New York on November 18.

Dr. W. M. Nicholson, Professor of Medicine and Director of Postgraduate Medical Education, has announced that shipboard lectures on various subjects in medicine, pediatrics and surgery will be presented by members of the Duke faculty. The instructional program will provide 20 hours credit toward postgraduate requirements of the American Academy of General Practice.

Further information may be obtained by writing to W. M. Nicholson, M. D., Director of Postgraduate Medical Education, Duke University School of Medicine, Durham, North Carolina.

## Blue Shield Plans Program Meeting In Chicago, October 10-11

The annual Program Conference of the National Association of Blue Shield Plans will be held at the Drake Hotel in Chicago, October 10-11. More than 300 Blue Shield Plans' physician-trustees and executives, as well as state and local medical society officers and secretaries, are expected to attend the conference.

Arthur S. Flemming, Secretary of Health, Education and Welfare, will be the keynote speaker. His subject will be "Voluntary Health Plans Today and Tomorrow."

Other speakers will include Dr. Norman A. Welch of Boston, Speaker of the AMA House of Delegates, and Dr. Donald Stubbs, Chairman of the Board of the National Association of Blue Shield Plans.

The Association announced that the October conference will replace the Blue Shield Professional Relations Conferences normally held each February.

### The Anatomy of An Accident

Accident is a word applied to the culmination of a series of events which result in harm to the individual or damage to property.

Accidents originate in unsafe acts. The end result of a small proportion of unsafe acts is an accident.

A small proportion of accidents result in accidental injuries. Accidental deaths are the end results of a very much smaller proportion of accidents.

In essence, no accidental death, no accidental injury, in fact no accident, can occur unless it is preceded by an unsafe act.

Therefore, the most important element that accident prevention programs must seek to eradicate are unsafe acts themselves.—A. L. Chapman, M. D., in Public Health Reports.

## Assn. of American Medical Colleges To Meet Oct. 30-Nov. 1

The 71st Annual Meeting of the Association of American Medical Colleges will be held at the Diplomat Hotel in Hollywood Beach, Florida, October 30-November 1.

There will be four scientific sessions, one on Sunday afternoon, October 30, two on Monday, and one on Tuesday.

The annual banquet is scheduled for Monday evening at seven o'clock, at which time Joseph T. Wearn, Ph.D., Vice President for Medical Affairs, Western Reserve University, will present the Third Alan Gregg Memorial Lecture.

Presentation of the Borden award in the medical sciences for 1960 and the Abraham Flexner award for outstanding service to medical education will be made during the banquet.

Full information concerning the program may be obtained by writing Lee Powers, M. D., Associate Director, Association of American Medical Colleges, 2530 Ridge Avenue, Evanston, Illinois.

## Medical Meetings, 1960

The following is a partial list of national, state and district medical meetings scheduled for 1960:

Sept. 1-2—Second Governor's Conf. on Aging, Charleston.
Sept. 10-11—Region II, ACS, White Sul. Spgs.
Sept. 13-15—National Cancer Conf., Minneapolis.
Sept. 16—W. Va. Heart Assn., Parkersburg.
Sept. 22-24—W. Va. Hospital Assn., White Sul. Springs.
Oct. 3—Medical Licensing Board, Charleston.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 8-9—Maryland GP Acad., Baltimore.
Oct. 9-14—Am. Acad. Oph. and Otol., Chicago.
Oct. 10-14—ACS. San Francisco.
Oct. 17-20—Am. Acad. Pediatrics, Chicago.
Oct. 21-22—S. E. Allergy Assn., Atlanta.
Oct. 21-23—PG Institute, Martinsburg.
Oct. 21-25—Am. Heart Assn., St. Louis.
Oct. 30-31—Southern Chap., ACCP, St. Louis.
Oct. 30-Nov. 1—Assn. American Medical Colleges, Hollywood Beach, Fla.
Oct. 31-Nov.3—Southern Medical, St. Louis.
Nov. 29-Dec. 2—AMA Clinical Meeting, Washington D. C.
Dec. 6-8—Southern Surgical Assn., Boca Raton, Fla.

## Southern Chapter, ACCP, To Meet In St. Louis, Oct. 30-31

The Seventeenth Annual Meeting of the Southern Chapter of the American College of Chest Physicians will be held at the Statler-Hilton Hotel in St. Louis, October 30-31, immediately preceding the annual meeting of the Southern Medical Association in that city.

A cordial invitation has been extended to all physicians to attend the ACCP meeting. There will be no registration fee.

Growing old is no more than a bad habit, which a busy man has no time to form.—Anon.

## Two Mental Health Workers Receive SREB In-Service Grants

Two in-service training grants totaling $560 have been awarded to mental health personnel in West Virginia by the Southern Regional Education Board. The awards were made by the Board under its program in mental health training and research.

The grants were made to Dr. David M. Wayne, director of the Bluefield Mental Health Center, and John L. Holladay, chief social worker at Hillcrest in Charleston.

Doctor Wayne will visit clinics in Baltimore to obtain aid in setting up a clinic to function as a research center for investigating new anti-depressive drugs in the treatment of mental disorders. Mr. Holladay will visit the Esther Loring Richards Childrens Center in Owings Mills, Maryland, to study residential cottage structure.

The SREB in-service training grants were made possible by a $90,000 grant for this purpose by the National Institute of Mental Health. Persons interested in applying for a grant should write to Southern Regional Education Board, 130 Sixth Street, N. W., Atlanta, Georgia.

## Public Health Association Meeting Planned in San Francisco

The 88th Annual Meeting of the American Public Health Association will be held in San Francisco, October 31-November 4. More than 5,000 people interested in the field of public health are expected to attend the meeting.

Dr. Berwyn F. Mattison, Executive Director, announced that the program will feature discussions on radiological health, health effects of food additives and genetic and environmental aspects of public health. Several sessions will be devoted to a thorough discussion of medical care programs and plans.

Among the highlights of the meeting will be the presentation of the highest awards in public health, the Sedgwick Memorial Medal and the Albert Lasker Awards of the APHA.

Further information concerning the meeting may be obtained by writing the American Public Health Association, 1790 Broadway, New York 19, New York.

## Dr. Geo. F. Lull New Medical Director Of Cook County DPA

Dr. George F. Lull, former general manager of the American Medical Association, has been named medical director of the public assistance division of the Cook County Department of Welfare, with offices at 69 West Washington Street, Chicago.

Doctor Lull has served as secretary of the Illinois State Medical Society since the death several months ago of Dr. Harold M. Camp.

## 17th Annual AAPS Meeting Planned in St. Louis

The 17th Annual Meeting of the Association of American Physicians and Surgeons' will be held at the Sheraton-Jefferson Hotel in St. Louis, Missouri, September 29-October 1.

Dr. Thomas L. Dwyer of Mexico, Missouri, Chairman of the Program Committee, has announced that the three-day meeting will feature addresses by authorities in the socio-economic aspects of medical practice. Election of officers will be held during a business session of the Delegates and Assembly which will be held on Saturday morning, October 1.

Senator Barry Goldwater of Arizona will be the speaker at the banquet on Friday evening, September 30.

Further information concerning the program may be obtained by writing to AAPS, 185 N. Wabash Avenue, Chicago 1, Illinois.

## Symposium on Clinical Chemistry In Cleveland, Nov. 9-11

The Frank E. Bunts Educational Institute of Cleveland, Ohio, affiliated with the Cleveland Clinic Foundation, has announced that it will sponsor a symposium on "Advances in Clinical Chemistry Methods" in Cleveland, November 9-11.

The symposium, which will be held in the North Clinic Building located at Euclid Avenue and East 93rd Street, will bring together authorities in the fields of electrophoresis, chromatography and pH.

Registration fee for the three-day meeting is $30.00, and will be limited to 125 physicians due to limitation of auditorium facilities.

Further information may be obtained by writing to Charles L. Leedham, M. D., Director of Education, Frank E. Bunts Educational Institute, 2020 E. 93rd Street, Cleveland 6, Ohio.

## Infectious Diseases—1960

Not only is providing rapid diagnosis of infectious diseases important to benefit sick individuals, but also the prompt detection of contagious diseases is necessary to safeguard large populations. Arising as a byproduct of jet travel have been nightmares among quarantine officials at international airports and among public health officials everywhere. The time spent in traveling around the world is shorter than the incubation period of most contagious diseases.

The rapid and accurate recognition of smallpox, yellow fever, malaria, amebiasis, typhoid fever, plague, and cholera may, at any time, prove to be a talent of inestimable value to society. In the past, patients with these diseases have been seen in clinics in the United States. To assume that "they can't happen here" is to assume that travelers cannot bring them, an assumption which is not warranted under the increasingly more complicated circumstances.—Maryland State Medical Journal.

## Dr. J. C. Huffman Refers First Patient To WVU Teaching Hospital

Dr. J. C. Huffman of Buckhannon, immediate past president of the West Virginia State Medical Association, represented state physicians at ceremonies held in connection with the official opening of the Teaching Hospital at the West Virginia University Medical Center in Morgantown on August 10.

Doctor Huffman also was given the honor of referring the first patient for treatment in the ultra-modern structure which has an ultimate capacity of 522 patient beds. Sixty-six beds are now ready for occupancy.

Presiding over the ceremonies were University President Elvis J. Stahr, Jr., Dr. Kenneth E. Penrod, Vice President—Medical Affairs, and Eugene L. Staples, Hospital Administrator.

Four patient rooms also were formally dedicated, all furnished through contributions to the West Virginia University Foundation, Inc., by Morgantown residents.

## Challenge to the Study of Medicine

Many factors influence the decision of a young man or women to prepare himself for and enter the study of medicine. On a national scale it seems certain that competition from other fields for talented young people is a major factor. Not only can a good college student easily step into a job good enough for him to begin to support a family and be independent, but also advanced study in other fields has caught the imagination of many young people.

A good college student can easily pursue graduate study in chemistry, physics, mathematics or most of the social sciences fully supported by a scholarship or fellowship that wil cover his tuition and provide for a modest living. And at the completion of this graduate study he can be confident of stable employment with a fairly good standard of living.

Throughout the fifties the number of Ph.D. degrees awarded in the physical and social sciences has risen in direct proportion to the decline in the number of applicants for medical school.—Robert C. Berson, M. D., in Journal, Med. Assn., State of Alabama.

## Oph. and Otol. Meeting in St. Louis

Dr. Albert C. Esposito of Huntington, secretary of the Section on Ophthalmology and Otolaryngology of the Southern Medical Association, has announced that the annual meeting of that group will be held in connection with the Southern Medical meeting in St. Louis, October 31-November 3.

Scientific sessions will be held throughout the meeting and a business session on November 2 will conclude the program.

Further information may be obtained by writing to Dr. Albert C. Esposito, 1212 1st Huntington National Bank Building, Huntington 1, W. Va.

# The West Virginia Medical Journal

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## Medical Society Responsibilities*

*J. C. Huffman, M. D.*

A doctor who practices medicine in West Virginia today should not fail to assume his responsibilities in the solution of our socio-medico-economic problems. He might say, "These problems do not concern me; my interest is in the care of my patients; why should I be concerned about medical care plans, medical legislation, cost of medical care or medical education?" However, the time is here when each of us must assume his individual responsibility to our State Medical Association.

It has become apparent to me during the past ten years that only through organizational effort can we accomplish our objectives. We need to acquaint ourselves with the problems at hand and then, through cooperative effort, solve these problems.

I would remind you of the remarks of my predecessor, George F. Evans, in his address just one year ago. He said: "Today, society is interested in the social and economic aspects of medicine and in a broader coverage of health and well-being for its people. Some believe that doctors are not concerned with these problems; perhaps we are not concerned enough, and therein may lie the danger to our freedom, our leadership and, inevitably, to the medical welfare of our people."

So I beg you as individuals, as members of our Association, and as members of the most altruistic of all professions, to familiarize yourselves with these problems.

### Medical Care Plans

Medical Care Plans were introduced to the medical profession and public approximately a decade ago. The one that deserves first consideration is our own Blue Shield Plan. We have eight such plans in West Virginia. They offer a variety of coverage for medical care to our citizens. These plans, although directed by members of our Association, leave much to be desired by both the policy-holders and physicians in various areas of our state. The responsibility for improvement in the services of these plans lies within the purview of our organization.

It behooves every member of our Association to become better informed about the various voluntary health plans, especially Blue Cross and Blue Shield, so that we may the better guide our patients in this direction rather than see them succumb to the evils of socialistic government control.

There has been considerable dissatisfaction expressed by some members of our Association with reference to the West Virginia Department of Public Assistance. It may be of interest to know that during the fiscal year 1958-59 this department spent $2,002,866 for medical care and that roughly one-fifth of this amount, or $400,000, went to pay physicians in West Virginia for their services, while 73 per cent represented hospital costs. The source of these funds is 49 per cent from the Federal government, 37 per cent from the state, and 14 per cent from the county.

This phase of medical care being purchased in West Virginia has been discussed by our Committee on Medical Economics and I am sure that more will be heard as the result of these deliberations. I believe that it is here that physicians should make their problems known so that their

### The Author

- **J. C. Huffman, M. D., Buckhannon, W. Va., Immediate Past President of the West Virginia State Medical Association.**

*Annual Address of the President, West Virginia State Medical Association, 93rd Annual Meeting, The Greenbrier, White Sulphur Springs, August 24, 1960.

representatives might be in a position to sit down with the administrators and try to work out a satisfactory solution.

Speaking of Government Medicine, namely Veterans Administration and Medicare plans, I have often wondered why we are so openly opposed to Socialized Medicine and yet accept these programs, recognizing full well that they constitute another advance into medical socialism. Certainly their fee schedules are attractive and some $300,000 from this source yearly has gone into the pockets of West Virginia physicians. This past year the figure has dropped to $115,000 for Medicare and I predict that it will go lower in the years ahead.

With reference to the VA Program, last year in the United States, only 39,000 of the 110,000 patients were being treated for service-connected disabilities. By 1971 the total service-connected disabilities will probably drop to thirty thousand and by 1986 to twenty-four thousand. By that time it is estimated that the total number of *non-service connected* disabilities will rise to 305,000.

We accepted these programs and in 1948 were called upon to provide medical care for yet another segment of our population under the program of the United Mine Workers Welfare and Retirement Fund. I need not remind you of the difficulties encountered with this program. Call these plans what you will, closed-panel, third party, prepaid medical care, or prepaid comprehensive medical care, the fact remains that they are here to stay!

The medical society in our neighboring State of Pennsylvania is now launching a broad educational program, the objectives of which are (1) to maintain the free practice of medicine, and (2) to place quality medical care within the economic reach of all segments of the population in that state. The proposed organizational chart is outlined with a Director of Medical Economics being employed. Under him will be the Public Relations Department, Legal Department, Department of Economics, and Department of Internal Affairs.

A plan for their citizens to pay for health care was adopted by the Society's House of Delegates. The preamble reads as follows: "Everyone should have available the best health care attainable. Tax funds should be available for the indigent. Self-supporting citizens can meet the increasing costs of modern medical achievements by the opportunity to join an adequate voluntary group prepayment plan that will help them budget for all their health care needs. The medical societies and the hospital council will cooperate with prepayment agencies and other interested parties to achieve this goal. The plan is intended to serve as a guide to those who are interested in financing health care."

We, physicians practicing in West Virginia, should assume our responsibilities in guiding all third parties in the procurement of quality medical care at reasonable costs.

**Medical Legislation**

In this year of 1960, important issues on the political scene that affect every physician have been brought to the front. The Forand Bill was considered and rejected by the House Ways and Means Committee, which eventually approved the Mills Bill. The Mills Bill was passed by the House of Representatives on July 2, 1960.

The Senate Finance Committee in the course of events received the Mills Bill and only yesterday two amendments were offered—one by Senator Javits of New York which would have been acceptable to the Administration, and the other by Senator Anderson which was in effect a duplication of the Forand Bill. Both were defeated.

Later in the day the Senate adopted by an overwhelming vote the report of the Senate Finance Committee. This bill is acceptable to organized medicine. I am sure that you read today of this action of the Senate.

Another bill of much interest to the medical profession which has been considered by Congress during the current session is House Bill 10, a proposal to provide a retirement program for physicians.

Lastly, Congress considered a bill providing for the compulsory inclusion of physicians under Title II of the Social Security Act.

The Senate which opened debate on House Bill 10 on June 29, 1960, failed to act on the measure before the recess. Although Senator Byrd, Chairman of the Senate Finance Committee, has spoken in favor of the bill as reported by his committee, there are a number of amendments being proposed by various senators which could sidetrack the measure.

The new law would affect all persons now subject to self-employment tax, as well as physicians and ministers who are not now covered. A self-employed individual would have to set up a retirement plan for his employees as well. He would be able to set aside up to 10 per cent of his income from personal services, or $2,500, whichever might be the smaller amount.

This bill is pending in the Finance Committee of the Senate.

The reasons for the opposition of the AMA to compulsory Social Security for physicians is that it does not fit the economic pattern of the practicing physician. Self-employed doctors rarely retire at age 65, therefore, the compulsory tax which would be imposed upon them were they covered under the Social Security system would be unjust and unreasonable. Physicians who are able to work prefer to keep right on practicing medicine. A recent survey shows that over 85 per cent of the physicians between the ages of 65 and 72 are in active practice. More than 50 per cent of the physicians who retire do so after age 74. Thus, if a compulsory Social Security bill were enacted into law the typical physician would be required to pay Social Security taxes until age 72 before he could receive benefits.

The House passed a bill which would provide compulsory Social Security coverage for physicians. However, the Senate later deleted this section. The matter is now in conference between the two houses.

It is the responsibility of every physician to become fully informed on each of these issues. After careful consideration he should make known his views to his congressman and both United States Senators so that they may be aware of the position of organized medicine on these important legislative matters. Here again we should be leaders, not followers. We must put ourselves into the political affairs of state and nation before it is too late and we find ourselves completely subdued by those who are in favor of government control of medicine. We can no longer sit back and wait for a committee, or a local or state organization to fight our individual battles. We must be prepared to fight for our freedom so that a free enterprise system of medical practice may prevail to the end that our citizens will continue to have the best medical care that is available anywhere in the world. Before we can do this effectively we must first put our own house in order, recognize our weaknesses, and correct them from the ground up.

### Cost of Medical Care

While we may not like to discuss the important and controversial subject of the cost of medical care, we are once again having our hand called by the public and politicians. I refer you to articles on the Cost of Medical Care in the October and November 1959 issues of *Life* magazine and in the January 1960 issue of *Redbook*, "Why Doctors Charge so Much—What Can Be Done About It."

Senator Wayne Morse of Oregon, in his article in the September 14, 1959, issue of *Medical Economics* under the title "We've Got to Regulate Doctors' Fees," says that "the medical profession does not have the moral right to charge whatever fees it chooses to charge; on the contrary, the Government has the duty to impose restrictions upon the medical profession similar to the restrictions imposed upon other economic groups whenever an economic group takes advantage of the people."

So with such challenges, I think it is our responsibility to be fully informed on this subject and, with that in mind, let's take a look at some facts.

In 1948 the public spent for medical care $7,749,000,000, and in 1958, $16,384,000,000. Out of each medical care dollar in 1948 physicians received 30 cents, and in 1958, 23.8 cents.

Private hospital care from 1948 to 1958 increased 166.4 per cent. Physicians' services increased 67.6 per cent, drugs, 122.4 per cent, ophthalmic and orthopedic products, 155.5 per cent, and other professional services, 72.8 per cent.

The Government's Cost of Living Index for the 20-year period, 1938-1958, shows that haircuts have gone up 206 per cent; shoe repairs, 171 per cent; food, 151 per cent; automobiles, 125 per cent; and men's clothing, 110 per cent. During the same period physicians' fees have increased 84 per cent.

There have been instances in which physicians' fees were excessive and it is these few members of our profession who are inviting government and third party interference and unfavorable publicity for the entire profession.

"Organized medicine must be enlisted in the fight to control the costs of medical care," states a monthly newsletter of Martin E. Segal & Co., consultants on welfare, health and pension plans.

The present position of the American Medical Association on closed-panel medical practice indicates that the profession can be expected to develop new methods to help meet the cost of medical care. The following are among some of the proposals:

1. Objective standards to determine the quality of medical care should be developed and applied by professionally competent judges.

2. The patient shoud know not only what the physician will charge him, but what the community and the profession consider a fair fee for the services he is to receive.

3. Wider use of diagnostic and preventive services would cut down the use of therapeutic services, thus reducing the cost of hospitalization and disability insurance.

4. Cooperation of the medical profession is also required to assure the proper development and operation of employee welfare plans.

The AMA has launched a program to study medical costs, and while this is a step in the right direction, I maintain that we physicians must accept this responsibility at the local level, since it is here that the complaints, misunderstandings and misinformation come into being. It is here that doctors individually and collectively must communicate effectively regarding fees and medical costs as they relate to other prices today.

As the standards of living increase, more money will be spent on hospital services. Rising wages leave more money for medical care. In a modern democracy the pressures on politicians to spend public funds on medical service are strong and promises in this direction provide bait for votes in political elections.

Factors considered responsible for these increasing costs of hospital care are emergency care for the indigent, wage increases for full-time hospital employees, increasing costs of training hospital personnel such as nurses, laboratory and x-ray technicians, shortage of skilled workers, and the increasing costs of food.

The third big factor in the cost of medical care has been drugs. One could spend much time in discussing this matter. Even though drugs have shown a 122 per cent increase during the past ten years, one must stop to consider the cost of research, manufacturing and marketing and then realize that drugs have helped materially in prolonging life, decreasing morbidity and shortening hospital stay. In many instances they have made hospitalization unnecessary. Many diseases that were once fatal can now be cured with drugs, and some diseases that were once crippling have been completely eliminated.

### Medical Education

I am sure that every physician in West Virginia is becoming increasingly interested in Medical Education. With the opening of our new four-year School of Medicine at Morgantown, each of us should feel that we are a part of this great endeavor. Our State Medical Association played a very important role in helping to establish this new school. It was largely through its influence that necessary funds were obtained to build this great Medical Center.

Our Association is proud to claim as a member such a man as Dean Edward J. Van Liere, whose name we will always honor as one of our great educators. This man has long been aware of the necessity of cooperation between the teaching institution and the members of the State Medical Association.

Our Association, and its individual members, must first become acquainted with the needs of medical education and then set about doing our part in meeting these needs. It is obvious that this cannot be done by one member or a select few. We must all become a part of the program.

We have already had much of the groundwork done by our West Virginia University Liaison Committee. This Committee can be utilized as a "bridge" between the School of Medicine and our Association. It will serve to evaluate and disseminate information to our membership by way of articles in *The Journal*, but better still by speaking before various organizations and societies.

Later, this Medical Center will be used for a part-time teaching service to our state physicians as a part of our postgraduate education. Very soon we will be privileged to use its facilities for consultation purposes.

It is true that many problems will arise, and already I have heard such remarks as, "What will be the admissions policy of the new hospital?" "Will they take any or will they take all indigent (DPA) cases?" "What about the UMW —will they send all their cases to the new hospital?" "Will there be a senior clerkship program established in our hospital?" "Is there going to be a preceptorship program?"

These and many more questions will be asked and it is important that we physicians keep ourselves informed. Not all of us can be teachers, but we can lend a helping hand to those in responsible positions who are helping to obtain additional practitioners of medicine for this great State of ours.

I urge you, as individual physicians and as members of the State Medical Association, to get behind this new institution and through education make West Virginia a better place in which to live.

### Physicians for a Growing America

From a report of the Surgeon General's Consultant Group on Medical Education I would like to leave with you a few facts for your consideration of this subject:

To meet the country's need for physicians for medical care, teaching and other essential purposes, an immediate and strenuous program of action by the nation as a whole is required. This program must safeguard and improve the quality of medical education as well as bring about the needed substantial increase in the number of physicians.

More physicians are going into research, teaching and industrial medicine. These types of services have made possible much progress in modern medicine, but have meant relatively fewer physicians devoting full time to patient care.

To achieve a graduation rate of 11,000 a year by 1975, there must be some 12,000 admissions to schools by 1971. This would be an increase of 50 per cent over the present number of admissions.

There are a number of serious obstacles to the achievement of this goal. Important among them are the many competing, attractive and challenging opportunities in other professional fields, the high cost of medical education, the long training period required, and the limitation of opportunity for medical education in many parts of the United States.

In spite of the opportunities for personal achievement, public esteem and community service, some able students are discouraged from even considering the medical profession by the number of years of advanced education required and by the cost of such education. Although scholarships and loans for medical students are available from numerous sources, the total amount of such support is inadequate. It does not compare to the amount of aid available to students in related fields.

**Need for Practicing Physicians**

A low ratio of physicians to population in a state strongly suggests a need for added medical education facilities. The average ratio for the United States is 126 active physicians per 100,000 civilian population. West Virginia, in 1957, had a ratio of 87 physicians per 100,000. It is estimated that by 1970 the figure will be 75 physicians per 100,000. (This is estimated on the present levels of graduation, assuming no migration of physicians from the state after graduation and no immigration of foreign graduates).

Awareness of these and other problems need not be too discouraging. The very fact that we are showing concern for them indicates growth, and it has been with progress.

My suggestion is that we *concentrate* on our own problems; *analyze* them as to their cause, effect and cure; *circumvent* them by anticipating and avoiding them; *overcome* them by continuing to demonstrate, as has no other profession in history, genuine concern for the welfare of others.

Solutions to these problems will not come readily or easily; worthwhile things never do. But I am counting upon you men and women of good will to achieve what may at times seem impossible. In agreement with Herbert Bayard Swope, "I cannot give you the formula for success, but I can give the formula for failure, which is: Try to please everybody."

I cannot close this account of my year's stewardship without telling you what a durable satisfaction it has been to represent physicians of your caliber. No one knows better than I that the West Virginia State Medical Association is composed of men and women of the highest integrity.

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# Origins of the Healing Art

If we consider medicine in its broadest aspects, we shall see that it is as old as man himself. Up and up, through millions of years, man has evolved to what he is today. And on through millions of years medicine has evolved to what it is today. Medicine is inherent, instinctive, ingrained in the very fibre of all living things. Medicine is as old as life itself. It is the primal instinct of all living things for self-preservation. It is the love and sympathy of parent for child, brother for brother, and man for man. This is the great driving force of the universe to which all other forces are subordinate. This affects the lowly bacterium and the higher reptile; the complex mammal and liberated intelligent man.—Irving I. Edgar, M. D., in Journal, Michigan State Medical Society.

# Ergot Intoxication in a Young Woman With Migraine*

## (Case Report)

*A. B. Curry Ellison, M. D.*

Ergot (Claviceps purpurea) is a parasitic fungus which grows upon rye and other grains. The contamination of edible grains by this poisonous fungus spread death and destruction for centuries, perhaps as early as 600 B. C. Ergotism from contaminated grain is not unusual in eastern Europe and Russia but has not been reported in this country.[1] If ergot intoxication is suspected, excessive drug administration must be considered as the most probable etiology.

The crude drug ergot contains many different compounds, a number of which have been isolated, the most widely known being ergotamine. In this discussion, we are particularly interested in the fraction ergotamine and its effect on the vascular system. Ergotamine produces peripheral vasoconstriction by direct action on vascular musculature and stimulation of the vasomotor center.[2, 3] In addition, this component and related alkaloids damage capillary endothelium, the mechanism of which is poorly understood. The combination of damaged endothelium and vascular spasm eventually can produce thrombi and gangrene.

In reviewing the history of ergot, Friedman, Von Storch and Araki[4] report that Eulenburg, of Germany, used ergot in the treatment of migraine, in 1883.

Wolfe[5] gives credit to Dr. William H. Thompson for the first use (1894) of ergot in the United States in the treatment of migraine. The drug in its crude form apparently was little used in the treatment of migraine.

Bluntschli and Goetz[6] published a good review of the development and action of the different ergot compounds. In 1906, ergotoxine was isolated by Barger and Carr, also by Kraft. Stoll, in 1918, isolated ergotamine, which is about half as toxic as ergotoxine. Maier generally is credited with first recognizing (1926) the benefit of ergotamine in the treatment of migraine. Stoll and Hoffman, in 1943, demonstrated that well defined compounds of the ergot alkaloids could be obtained by hydrogenating the readily reducible double bond of their lysergic acid and producing a new compound, dihydroergotamine. The hydrogenated derivatives were said to be less toxic and less emetic than the original alkaloids, with increased sympathicolytic effect and diminished or abolished direct action on smooth muscle.

Following the development of dihydroergotamine, various combinations of ergot alkaloids, i. e., with caffeine, sedatives, anti-emetics and other substances have been introduced for symptomatic relief of migraine.

Horton, Ryan and Reynolds[7], in 1948, introduced an oral tablet containing ergotamine tartrate and caffeine which was fairly successful in this regard.

Ergot preparations for use rectally have been discussed by Kadish,[8] Blumenthal and Fuchs,[9] Graham,[10] and many others, and sublingual tablets of ergotamine have been recently introduced.

The symptoms of ergot intoxication have been classified into two types by Velkoff and Ferguson,[11] Von Storch,[12] and Yater and Cahill.[13]

(1). Central nervous system: The symptoms of toxicity in this group are headache, vertigo, nausea, convulsive seizures, thirst and confusion, followed by syncope and depression, which may become a severe psychotic disturbance.

(2). Gangrenous type: This group is manifested by paresthesias, anesthesias, muscular pains and cyanosis of extremities progressing to gangrene. Many other symptoms have been described in patients with ergot intoxication, some of which have been considered to be functional in origin.

It has been pointed out by Von Storch[12] that most of the symptoms of ergotism have been elicited from patients who have ingested whole ergot. Other active constituents of ergot may

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Submitted to the Publication Committee, March 10, 1960.

mask or alter the toxic manifestations. The quantity of ergotamine causing toxic symptoms apparently is variable and preexisting conditions have been incriminated in producing severe toxic reactions.

Gould, Price and Ginsberg[14] report the case of a patient who developed pain and coldness of the legs after the second 0.25 mg. injection of ergotamine tartrate and expired after the fourth injection. In their discussion, they cite an instance of a patient who expired after the injection of one ampule of ergotamine tartrate.

Friedman, Brazil and Von Storch[15] report five patients who had taken large doses of ergotamine without apparent ill effects. One of these had taken 1.5 to 2.25 mg. of ergotamine tartrate daily for a period of eight years (total intake between 4,380 and 6,570 mg.). Another had taken ergotamine tartrate or dihydroergotamine tartrate for fifteen years, with a total dosage of 4,650 to 7,650 mg. tartrate. Friedman, Von Storch and Araka[4] report the case of a patient who had taken from 2.0 to 4.0 mg. of ergotamine tartrate by oral or parenteral route for over eighteen years without noticeable ill effects.

Peters and Horton[16] report 19 cases in which excessive quantities of ergotamine were used in migraine, and in six of these the patient had no symptoms of toxicity. Of the 13 cases in which there were toxic symptoms, none was severe enough to cause loss of life or limbs. These authors point out that there also can be a gynergen withdrawal type of headache, as demonstrated in seven of their cases.

The generally accepted contraindications to use of the drug are: (1) preexisting infection such as puerperal fever, (2) exophthalmic goiter, (3) liver disease, (4) vascular disease, (5) severe hypertension, (6) pregnancy and (7) hypersensitivity to the drug. Recent publications by Fuchs and Blumenthal,[17] also by Peters and Horton,[16] would indicate that coronary artery disease should be added to the list.

The most frequent serious vascular complication noted in the literature is gangrene of the extremities, as reported by Yater and Cahill,[13] Cleveland and King,[18] and many others. A less frequent complication is coronary occlusion.[17] Angina aggravated by ergotamine has been reported by Peters and Horton,[16] and by other observers. Neuroretinitis with optic atrophy has been reported by Kravitz.[19] Yater and Cahill[13] mention a case in which there were severe anginal pains, hemiplegia and jacksonian epilepsy following the use of ergotamine, citing Labbe, Banlin, Justin-Besancon and Gouyen.

The method of administering the drug certainly must have some bearing on its toxicity and effectiveness. Parenteral injection seems to be the most effective and sure way of absorption of the drug. During an attack of migraine, it is not unusual for the patient to have spasm of the antrum of the stomach, with retention,[20] so that tablets are not absorbed and may be vomited several hours after ingestion. In this type of patient, parenteral, sublingual or rectal administration is preferable.

### Case Report

A 27-year-old white, married female entered Charleston Memorial Hospital on November 3, 1958, complaining of "painful feet and legs" of four weeks' duration and "migraine headaches" since the age of thirteen. The headaches always occurred in the right temporal area and were preceded by a "funny feeling" over the right eye and sometimes by scotomata. The headaches usually were associated with nausea and vomiting, the latter lasting about twelve hours. The scalp, as a rule, was tender to touch the next day. At times, there was associated stuffiness of the nose on the right side. The longest interval free of headache in the past six years was one month, in 1952. At times, she had headaches daily and during the past twelve months before admission to the hospital, she might have three attacks daily, localized in the same area of the head, but not as severe and usually not associated with scotomata, nausea and vomiting.

Gynergen, dihydroergotamine and cafergot PB suppositories were first used by the patient in 1955. On January 17, 1958, she had an episode of numbness and tingling of the feet, lasting a few days. She was advised by her home physician to stop all headache medication, but failed to follow his advice. On October 4, 1958, the patient was given one ampule of gynergen and one ampule of DHE 45, following which she complained of the painful feet and legs. During the four weeks before admission to the hospital, she had intermittent claudication of both legs and buttocks in walking up one flight of stairs. Her feet were so hot and painful (St. Anthony's fire) that she could barely walk. The hyperesthesia was so severe that bed linens touching the feet kept her awake. She had noted that the legs and feet were reddish-blue in color. From November 1, 1957, to November 1, 1958, she had taken 936 cafergot PB suppositories. This was an average of 2.61 suppositories daily for 365 days (5.22 mg. ergotamine tartrate daily), or a total of 1,872 mg. taken rectally in one year.

The past history was noncontributory, other than sterility of five years' duration. The family

history revealed that her father also had migraine.

The essential physical findings were dilated pupils with grade II attenuation of the retinal arterioles. Blood pressure was unobtainable in the left arm but was 130/90-80 in the right arm. A positive Allen test was found on the left hand and the circulation to the right hand was decreased (minus 2). The femoral arteries were open, both popliteals minus two, both dorsalis pedi were absent, minus four, and both posterior tibials minus three, these graded on the decreasing basis of one to four. There was dependent rubor, grade II. Neurologic examination was negative. Complete blood count, urinalysis, sedimentation rate, blood serology and x-rays of the chest and skull were normal.

Treatment in the hospital consisted of whiskey 45 cc's. every six hours, perphenazine (Trilafon) 4 mg. four times daily, azapetine phosphate (Ilidar), one tablet four times daily, therapeutic vitamin, one daily, APC and dextropropoxyphene hydrochloride (Darvon) 65 mg. every four hours or as needed, for pain. All ergot preparations were stopped. In five days the arterial pulsations returned to normal and the paresthesias were markedly decreased. Four weeks after stopping the ergotamine, the feet were "about normal."

The patient was placed on mild sedation at home and has had a mild headache about once each month until June, 1959. Following withdrawal of the ergotamine in the hospital, she had daily mild headaches for three days.

### Discussion

Mild reactions such as nausea and emesis are quite frequent in patients taking ergotamine. Other mild reactions include intestinal colic, diarrhea, giddiness, restlessness and thirst. Less frequently, one sees patients that have fairly severe pain in the legs and, in our experience, much less often in the upper extremities. In a few instances, pain in the extremities has been so severe after one injection or a single suppository of ergotamine that the drug was discontinued.

Our patient had none of the contraindications listed above that we could determine by history or physical examination. The toxicity in her case was due to an abuse of the drug, which was taken in doses far in excess of that recommended for treatment. The practice was perpetuated by the patient's having a prescription which could be refilled indefinitely without adequate professional supervision and follow-up. This represented chronic ergot poisoning rather than the rarely encountered acute ergot intoxication.

The treatment of chronic ergotism is, first, withdrawal of all ergot preparations and, second, promotion of vasodilatation with such agents as alcohol, nicotinic acid and various ganglionic blocking agents.

This patient responded very satisfactorily to withdrawal of ergotamine, azapetine phosphate (Ilidar) and whiskey within a relatively short time. Fortunately, no permanent damage can be detected at this time.

Another interesting facet is that the patient was having withdrawal headache, as discussed by Peters and Horton,[16] and Friedman, Brazil and Van Storch.[15]

### Summary

A brief review of the literature is given.

A case of ergot intoxication in a young female who had taken 1872 mg. of ergotamine tartrate per rectum in 365 days, or an average of 5.22 mg. daily, is presented.

Ergotamine is relatively safe and effective for the symptomatic treatment of migraine, but the drug always should be used judiciously.

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# Who Will Be Our Successors?

The present status and the future prospects of enrollment in our medical schools has been called to our attention by government agencies, economists, and our own national organizations. The quality of the present applicant has given our medical schools concern.

In 1950, 5.1 per cent of college graduates applied for admission. In 1958, the number dropped to 4.1 per cent. "A" grade applicants decreased; a decline in quantitative aptitudes and scientific skills as measured by aptitude tests. Freshman withdrawal during the freshman year increased from 5.5 per cent in 1954 and 1955 to 7.8 per cent in 1957 and 1958. This made fewer students available for the second year.

Aside from the quality student, faculty vacancies in 1957 and 1958 were twice that reported for the period of 1956 and 1957. Twenty medical schools reported an average need of fifty additional faculty members.

In 1959, there were eighty-six medical schools in the United States, including four two-year schools. These would admit 8,250 students in 1960. Expansion and rehabilitation would permit these to admit 9,400 in 1966. It is clearly apparent there is a shortage of physicians and teaching facilities in our country in relation to the present rate of population increase. Assuming that by 1975 there will be 235,000,000 people, 310,000 physicians would be needed to maintain the desired 132 physicians to 100,000 population. At the present time, there are approximately 230,000 physicians in practice and research.

Among the factors which account for the present decline of qualified applicants are the long years of formal training as compared to other professions. Counting premedical training, up to nine years are required to prepare for general practice and from twelve to fifteen years for the special fields. The increase in the number of married students has become significant. In 1956, 55 per cent, and in 1958, 68 per cent of students in medical schools were married. Twelve per cent had two or more children in 1956; in 1958, the number had increased to 24 per cent.

These factors loom as economic barriers to many. At best can we postulate that the medical student of today is superior in dedication, stability, and motivation by virtue of meeting these formidable obstacles and overcoming them? Surely, he has additional preparation for better understanding and maturity to fulfill his duty to his patients.

Leaders in medical education are re-evaluating the curriculi and in some schools have succeeded in shortening the period of preparation with the view of maintaining and possibly improving standards.

We, as physicians, can renew our efforts in our local communities to interview and encourage high school students who indicate interest in medicine. Several county societies have organized groups or "clubs" with these young aspirants with success. Our high standards as a profession will be jeopardized if we fail to realize our precarious situation. We must be aroused as individual physicians to act before we are compelled to submit to bureaucratic control.—Clarence Jacobson, M. D., in Minnesota Medicine.

# Pleural Biopsy and Pleural Fluid in the Diagnosis Of Thoracic Disease

*Charles F. Ballou, III, M. D.*

Pleural effusion of sudden onset has been a problem to physicians from the earliest days of medical history. Since the advent of the roentgen ray for diagnostic purposes, the sudden appearance of effusion without underlying cause seen on the chest film, often happens to plague the physician with the problem of differential diagnosis, even in this era of advanced diagnostic techniques.

Until recently, detailed study of the pleural fluid itself by cytologic and chemical means and by cultures, constituted the only diagnostic weapon available. The procedures involved, time-consuming and, at best, furnishing only vague answers, rendered the study of little value with regard to the over-all diagnostic picture of the idiopathic pleural effusion.

In recent years, however, new techniques, including pleural biopsy, have enabled us to make a more rapid and precise diagnosis when faced with the problem of idiopathic effusion and in great measure have released us from playing diagnostic percentages, as it were, after an analysis of the pleural fluid alone.

The purpose of this paper is, first, to furnish an outline of the etiology of pleural fluid as regards its pathologic physiology, and some of the diagnostic possibilities and inadequacies encountered when investigative efforts are confined to its study alone; second, to discuss the technique and general aims and advantages of pleural biopsy; third, to describe the over-all diagnostic attack which it is believed should be made on the unexplained pleural effusion, and the role that pleural biopsy plays in this attack.

The causes of pleural effusion, from the standpoint of pathologic physiology, generally are conceded to be three in number: (1) increased pressure in the subpleural capillaries, for example, congestive heart failure, the superior vena cava syndrome and constrictive pericarditis, (2) decrease in the blood osmotic pressure as seen in the various diseases with hypoproteinemia and (3) direct involvement of the pleura by trauma, neoplasm, infection or vasculitis.

As mentioned previously, investigation of the cause of an effusion when, limited to a study of the pleural fluid, is restricted to chemical, cytologic and culture studies and is dependent to a great extent, also, on the acceptance of well established medical dogmas, built up over many years, such as these:

1. Idiopathic effusions are tuberculous until proven otherwise.
2. Eighty per cent of idiopathic effusions are tuberculous.
3. Pleural transudates are secondary to congestive heart failure or constrictive pericarditis.
4. Pleural exudates of a serous nature generally are tuberculous.
5. Serosanguineous exudates are malignant in origin.

Granted that as high as 65 per cent of unexplained effusions will turn out to be tuberculous in five years and that the other statements tend to be true, various investigators have found marked discrepancies in these declarations, which further cloud the picture of idiopathic pleural effusion when its study is restricted to examination of the pleural fluid.

An example of this is the Mayo Clinic report of Llewellyn and Carr with regard to a study of 436 cases of pleural effusion. These observers found that only 62 per cent of their serosanguineous fluids eventually were shown to be due to malignancy and conversely, that 45 per cent of the serious effusions were neoplastic in origin. Regarding "Dogma" No. 3, that transudates are due to congestive heart failure alone, we find again in the same series of cases that 28.1 per cent of fluids were of a specific gravity of 1.016 or more in cases in which congestive failure was the only disease found, whereas 27 per cent of their fluids secondary to proven tuberculosis or neoplasm were of a specific gravity below the same figures, distinctly a transudate. In our own experience, we have found that a total protein of 3.0 Gm. per cent or more is the best dividing line of the transudate from the exudate.

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Submitted to the Publication Committee, March 31, 1960.

Bacteriologic study of the pleural fluid, especially as regards tuberculosis, is highly inadequate and generally 25 per cent or less "positives" have resulted in most series. Moreover, the length of time required for the culture to grow in the laboratory, with the economic cost and time loss to the patient, adds up to a price too high for a procedure which is only 25 per cent accurate.

Cytologic studies have been found to be extremely inadequate; for example, the average number of cases in which cancer cells are found, cases ultimately proved to be malignant in etiology, is 50 per cent. Conversely, and further clouding the issue, is the high incidence of false positives for malignant cells in the pleural fluid, often as high as 10 per cent, because of the understandable confusion between malignant and normal pleural mesothelial cells, both of which show extensive mitotic figures and cell division on microscopic examination. We may readily see that a rapid differentiation of tuberculous versus neoplastic effusion is the main problem facing the clinician, first, because of the seriousness of both disease entities and, second, because their diagnosis is so often presumptive when the fluid alone is studied.

As mentioned before, as high as 65 per cent of unexplained pleural effusions eventually will be found to have become open cases of tuberculosis in five years or less. The dangers of a missed case of neoplastic disease are obvious. Also, the economic loss because of a lengthy hospitalization, pending a proper diagnosis, and the danger of spread of a lymphohematogenous tuberculosis during this period are self-evident. Thus, there is need for a procedure that is easily performed by the physician, that requires the minimal amount of equipment and, to say the least, that will cause the least amount of expense and time loss to the patient, which can readily be used to separate more quickly the tuberculous from the malignant or non-tuberculous effusion. We feel that pleural biopsy greatly fills the need for such a procedure. In our experience, the positive yield in effusions due to eventually proven tuberculosis is between 75 and 80 per cent.

### The Procedure

One of the first reports on pleural biopsy was made by Lloyd, in 1953. In his series the biopsy was done in coordination with thoroscopy which had been practiced in Europe for many years. In 12 of Lloyd's 16 cases, a histologic diagnosis was obtained. Needle biopsy of the pleura received little attention until De Francis, Albano and Kloch, in 1955, revived interest in the procedure, using a Vim-Silverman needle. Subsequent investigators, especially Katz and his group, have published extensive data on this technique, the positive tissue diagnosis in proven tuberculosis cases being as high as 80 per cent.

The technique is simple, can be performed at the time of the first thoracentesis, and entails no risk to the patient other than the usual ones encountered in the procedure, these being the possibility of pneumothorax, hemothorax, the possible spread of malignant cells, and possible introduction of infection. There has been little, if any, evidence of a secondary cause of hematogenous spread of tuberculosis. The only contraindication to the procedure is a bleeding diathesis. The advantages over an initial open chest biopsy requiring the use of an operating room, surgeon, and an anesthetist, are obvious. The open biopsy, however, has its place in the overall attack on the problem of the idiopathic effusion, which will be discussed later.

The technique which we use is that described by De Francis, with the omission of his initial skin incision because of its necessitating the use of a suture and thereby unnecessarily increasing the time of the procedure. The equipment consists of a standard thoracentesis tray plus a Vim-Silverman needle and a Kelly clamp.

The fluid is located by x-ray or fluoroscopy and the overlying skin is cleansed in the usual manner. The skin and subcutaneous tissue are infiltrated with novocain down to the parietal pleura and the pleural space is entered. At this time, fluid for routine studies such as cell count, specific gravity, protein and differential cell examination should be drawn. The reason for this is that trauma of the biopsy at times will cause a slight amount of bleeding, thus altering these studies to a great degree if done on fluid withdrawn after the procedure.

When the fluid is encountered and withdrawn, the needle is withdrawn to a point at which the flow of the fluid suddenly ceases on negative pressure from the syringe. At this point, the Kelly clamp is fastened to the needle at the skin surface, and the needle is then withdrawn, thus giving the operator an idea of the depth of the pleura from the skin. This measured length is then transferred to the biopsy needle. The biopsy needle is then inserted and advanced, the trocar in place, to the depth of the Kelly clamp. The trocar is then withdrawn and the biopsy shaft is inserted until resistance is encountered. At this point, it is forcibly advanced to the hilt, the outer sleeve of the needle advanced, the biopsy needle rotated 360°, and then withdrawn in the same manner as a liver biopsy. The outer sleeve should then be covered with a gloved finger to

keep air from entering the pleural cavity until the obturator can be reintroduced. With practice, the needle may be reintroduced toward the parietal pleura and several specimens collected without reintroduction of the large needle through the skin. We have found also that in the presence of a markedly thickened pleura, by x-ray examination, little or no pleural fluid need be present for a successful biopsy, as a marked pleural symphysis is present, preventing occurence of pneumothorax. When this variation of the technique is used, the positive biopsy yield has been generally lower, in the vicinity of 30 per cent.

The tissue obtained usually is a specimen approximately 1 mm. by 2-4 mm. and generally greyish in color. We have found frequently that on gross inspection pleural tissue is generally indistinguishable from skeletal muscle; hence, the need for removal of several specimens during the course of the procedure.

Microscopically, we feel that a positive yield should consist of a specimen made up of loose or dense fibrous tissue, preferably attached to skeletal muscle, and with mesothelial cells lining some of the specimen.

A positive diagnosis for tuberculosis consists of the above described specimen containing typical tuberculous granulomata. Most investigators have found that extensive staining, using PAS, Gridley, and acid fast stains, has been unrewarding as regards the identification of specific organisms. It is necessary to point out that a granulomatous pleuritis may be demonstrated in histoplasmosis, sarcoidosis, brucellosis and tularemia, as well as secondary reactions to the introduction into the pleural cavity of the sclerosing substance, such as talcum powder or suture material. In any event, the history and clinical course, coupled with the appropriate skin tests and serologic studies can effect an easy correlation with the biopsy findings, and the granuloma in question properly identified.

At times, the study of the pleural fluid, along with a pleural biopsy, may be inadequate to diagnose the specific cause of the effusion. Needle biopsy may reveal either inadequate tissue obtained, or result in the finding of nonspecific pleuritis on several attempts at biopsy, with no definite granulomata being noted. Since all of the granulomatous diseases, some collagen diseases, and also malignancy, may cause this latter finding on microscopic examination, we recommend as the next step, open pleural biopsy. This generally is effected by a 7 to 10 cm. incision made in the fourth intercostal space anteriorly. A large strip of pleura is removed for rapid section examination and culture. If specific diagnosis still is not found, it is further recommended that a full exploratory thoracotomy be performed at this time, and a pulmonary process be sought for the specific cause of the effusion.

### Summary

The technique of pleural biopsy is discussed. The 70 to 80 per cent yield in effusions of tuberculous origin is noted and its obvious effectiveness for a rapid diagnosis is discussed. The place in which this technique fits in the over-all attack on unexplained pleural effusion is noted, and the necessity of open biopsy is stressed as being mandatory for final evaluation of the effusion, if the needle biopsy technique proves unrewarding. The questionable benefit of evaluation of fluid alone because of the many overlapping findings in malignancy and tuberculosis are mentioned, and the pitfalls in diagnosis when fluid study alone is relied on are pointed out.

### Acknowledgment

The author takes this opportunity to thank Dr. Sol Katz for his help and advice in the preparation of this paper.

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*. . . the natural role of 20th century man is anxiety.*

NORMAN MILLER.

# Hepatoma in Childhood*

## (Case Report)

*J. Evan Sadler, M. D.*

THE prognosis for malignant neoplasm of the liver in children is extremely poor, recoveries not having been recorded and survivals averaging four months.[1]

As in many neoplastic diseases, which were originally considered hopeless, an occasional case survives to encourage our further efforts. The following patient has had a malignant hepatoma and has now survived for a period in excess of 18 months.

### Case Report

A 5-year-old female, born November 19, 1952, was admitted to the hospital June 6, 1958, with an acute respiratory infection. When her abdomen was palpated, a mass was found anteriorly in the right upper abdominal quadrant immediately beneath the right costal margin. The mass was smooth, nontender, soft and not movable, and inasmuch as its identity could not be determined by the usual diagnostic studies, an exploratory laparotomy was performed June 28, 1958. A large, firm, rounded mass was felt in the right lobe of the liver and was excised, removing approximately one-fifth of all hepatic tissue.

The piece of liver measured 8.5 x 7.5 x 6.0 cm. and contained an ovoid, indurated, grey-pink, bulging mass which measured 5.0 cm. in diameter. The surface of the mass was coarsely granular and stained with bile in a few small zones.

Microscopically, the mass was made up of columns and cords of proliferating disoriented hepatic cells. Stromal invasion and extension into surrounding hepatic tissue was demonstrated. Numerous thick strands of eosinophilic collagenous material traversed the central portions of the mass. Many of the proliferating cells contained grey-brown pigment granules and bile plugs were present in canaliculi which were formed by the proliferating cells. The histologic diagnosis was "hepatoma-malignant."[2-3]

Subphrenic abscess, subhepatic abscess and incisional abscesses developed. The last surgical complication, a fistula in the incision, was excised successfully January 26, 1959. As of January, 1960, the child is well and has no symptoms of any disease.

*From the Pathological Service, Cabell-Huntington Hospital, Huntington, W. Va.

Submitted to the Publication Committee, May 3, 1960.

*The Author*

- J. Evan Sadler, M. D., 2065 Donald Avenue, Huntington, W. Va.

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*. . . he is the best physician who is the best inspirer of hope.*

W. S. MIDDLETON.

# Special Article

# The Military Medical Aspects of Modern Weapon Systems*

*Richard L. Meiling, M. D.*

I feel particularly honored in being selected to present this, the third annual Paul R. Hawley Military Medical Lecture. It was my good fortune to be associated with Maj. Gen. Hawley during 1948-1951 on several government policy and program committees involving our National Security; hence, I can speak from personal knowledge of Doctor Hawley's loyal devotion to his country, to the medical profession, and to the Army.

Doctor Hawley's well merited reputation, both nationally and internationally, as Chief Surgeon of the U. S. Forces in the European Theater of Operations during World War II, Chief Medical Director of the Veteran's Administration 1946-1947, Chief Executive Officer of the Blue Cross and Blue Shield Commissions 1948-1950, and Director of the American College of Surgeons is well known both to American physicians and laymen.

I should like, however, to recite an incident in Doctor Hawley's life personifying the qualities of physician and military officer which should be the goal of every military physician during peace or war, be he regular or reservist, assigned to the Army, Navy, Marines or Air Force.

In the spring of 1931, Doctor Hawley, a major in the United States Army regular corps and classified as a specialist in "preventive medicine" was assigned to the Nicaragua Canal Survey with headquarters at Granada. At Managua, some fifty miles distant, there occurred a great earthquake. Doctor Hawley, with four medical enlisted technicians and two field chests (MD-US Army), in one of which was a general operating case, was dispatched by train to the disaster, with one company of U. S. Engineer troops.

On arrival at Managua they found the city in ruins, including the U. S. Navy Hospital located at Campo de Marti. There were three U. S. Navy doctors and Doctor Hawley available. All the Nicaraguan doctors who survived the quake had fled to the hills with their families. More than 2000 injured were already at the site of the destroyed U. S. Navy Hospital and for the next 72 hours these four U. S. military physicians were the only physicians available.

Doctor Hawley recalls standing at the operating table, set up in two twenty-foot Army tents, doing guillotine amputations for thirty-six hours without a break. He wore the same rubber gloves, immersing his gloved hands in 5 per cent phenol between cases.

Fortunately, the brewery was left standing and the owner sent tubs of ice and cases of beer to the "tent hospital." Doctor Hawley would have an enlisted man hold a cold bottle of beer to his lips while he immersed his gloved hands in the phenol solution between cases. After the emergency work was completed, he agreed to accept 75 cases of fractured femur (many of them compound) at his station in Granada. These patients were transported by train, and the Navy lent him two well trained hospital corpsmen. He also secured the services of missionaries to act as nurses.

His first problem was how to apply traction. Adhesive tape was out of the question in the tropics and he had no orthopedic devices. Our resourceful military medical officer, Doctor Hawley, drew a design for an ice-tong type bone caliper and had his engineers supply him with some 1″ strap iron. Two Nicaraguan blacksmiths hand forged the tongs, roughened the places where the two halves touched, used an iron bolt with a ring nut as hinge and drew the points to slender cones with sharp points. For handles they used ½″ manila rope. Balkan frames were then constructed from mahogany wood. Infection was fought by wide incision and drainage,


### *The Author*

- **Richard L. Meiling, M. D., Associate Dean and Professor of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus, Ohio; Brig. General, U. S. A. F. (Res.).**


*The Paul R. Hawley Military Medical Lecture, Veterans Administration Hospital, Huntington, W. Va., February 11, 1960.

Submitted to the Publication Committee, February 11, 1960.

for this was before the day of sulfonamides and antibiotics.

None of the patients died. Doctor Hawley says "perhaps a few could not have become ballet dancers, but they could all earn a living and support themselves."

This is but one of many incidents in the life of Doctor Hawley, the specialist in preventive medicine, the clinician, the rehabilitation expert and, above all else, the physician who responded daily to the motto of the military medical service, "Maintain the Fighting Force," from his entrance on active duty in 1916 to his retirement as a Major General in 1946.

Today's and tomorrow's problems of military medical service are concerned with many new scientific and technical developments, but we dare not forget the sanitation and hygiene lessons learned in the Civil War, the Spanish-American War, and in World War I. It was during World War II and the Korean War that for the first time military weapons claimed more military casualties in the American Armed Forces than did disease.

Yet it is with deep concern that the medical profession learned that more than 30 per cent of the U. S. Forces engaged in the Lebanon landings in the fall of 1958 fell casualty to gastrointestinal disease due to faulty sanitation and hygiene during the first eleven days of the campaign. Still later, U. S. troops returning to Europe spread these dysentries to others and to their dependents on the European bases. This bespeaks forgotten lessons and questionable planning at the highest level of our Defense Department. It is difficult to understand the reported absence of military hygiene discipline and the absence of insecticides, sprays and fogging apparatus among American troops entering an area such as Lebanon. Preventive medicine and anticipatory planning still are fundamentals which dare not be neglected.

Gen. Maxwell Taylor has recently stated, "The National Military Program must be suitable for flexible application to unforeseen situations. It cannot be geared to any single military weapons system, strategic concept or combination of allies." (*The Uncertain Trumpet*).

It matters little whether we subscribe to the strategy of "Massive Retaliation" or of "Flexible Response." We as physicians have a principle role to play, namely, "Maintain the Fighting Force." Let us then look at some of the medical problems associated with the modern weapons systems.

The various radio frequency equipment systems for the detection, control (radar) and communication systems are known to produce certain microwave radiation hazards (electromagnetic radiation hazards). These hazards are the result of a combination of power, densities, frequencies, exposure times and shielding. For example, with radar, the power must be radiated into free space if it is to be of value. So long as our military apparatus has a 10 megawatt output and the antenna is directed to the horizon at any upward angle, the problem is not too perplexing, but tomorrow we may have systems with 100 or even 1,000 megawatt power source. In this field, we find need for a team of specialists, including biologists, electronic engineers, physicists and physicians. To date no known incidents of serious injury or death can be properly attributed to exposure to the beam of a radar set. Yet to walk between the feed and the antenna would be extremely hazardous and on the close quarters of a radar search ship problems may develop because of limited areas. Physical examinations on maintenance and repair personnel assigned to radar generators include ophthalmologic, stool and urine for occult blood, CBC, capillary fragility test and chest x-ray. (Animal experiments have produced lesions from over-exposure to microwaves. These lesions include cataracts of nonthermal origin and blood dyscrasias). Communication systems using microwaves in the 400 megacycle band are used by the U. S. Navy to transmit radio photographs from the 84 ft. dish antenna at Annapolis to Hawaii, by way of the moon, a mere 480,000 mile trip but one apparently unaffected by magnetic storms which might prevent a direct 4,850 mile transmission between these two stations.

Noise associated with jet propelled aircraft on bases and particularly aboard carriers presents physiological effects, interference with speech and physiological damage such as nausea, blurred vision and hearing loss. The "sonic boom" can and, on occasion, does destroy property. We use the decibel (a logarithmic unit which expresses the ratio between two sound pressures) scale to measure sound. Medical officers must understand the degree of protection afforded personnel by protective devices and methods of minimizing exposure time to intense noise.

The age of rocketry, missiles and space vehicles has produced numerous medical problems. As you know from public announcements we have an ICBM (Intercontinental Ballistic Missile) now operational and assigned to the Air Force. I refer to the Atlas. We also have IRBM, such as the Thor, available on an operational basis. Under development we have the Polaris for use aboard the newest nuclear powered submarines, and the Titan. On the 1963-1965

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*sustains*
*retains*

*extra*
*antibiotic*
*activity*

# DEC

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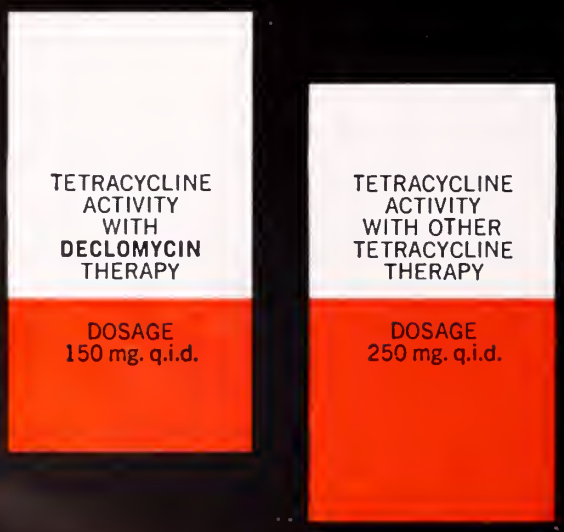
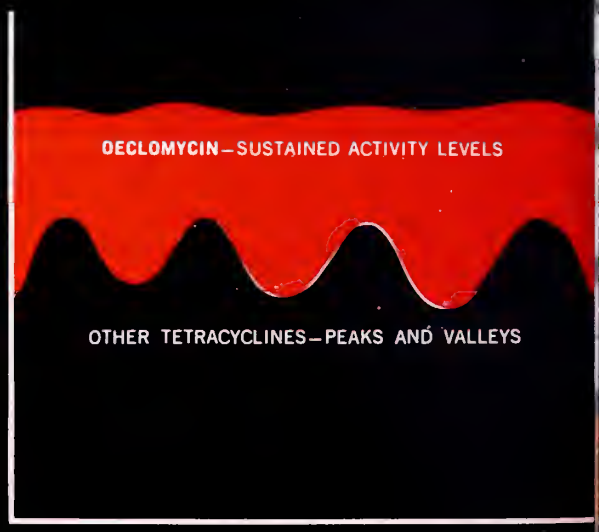



POSITIVE ANTIBACTERIAL ACTION

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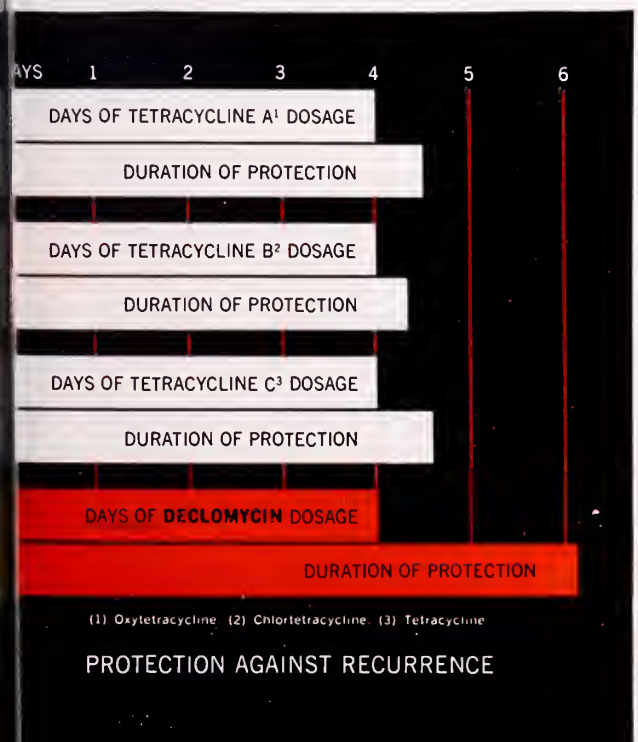


CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

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schedule are solid fuel missiles such as the Minuteman.

For those who have not seen a missile such as the Atlas, let me describe it as follows: The Atlas is a "weapons system" involving some twenty-two industries, eighty thousand workers, the AEC (for information on war heads), the Coast and Geodetic Survey (for precise placement of launch and guidance) as well as the Department of Defense and the Air Force.

The Atlas itself is approximately 10 feet in diameter and taller than a seven story building.

The propellant (more than 225,000 lbs.) is a hydrocarbon mixed with an oxidizer, in this case, liquid oxygen (temperature of -297° F). When this ignites the temperature is instantly in excess of 5000° F. The thrust goes from zero to 360,000 lbs. at take-off. This is five times the horsepower generated by the turbines at Hoover Dam.

Within four to five minutes of launch this missile has attained a speed of approximately 16,000 miles per hour. It has a range of more than 6,000 miles or, if you will, the equal of a trip from San Francisco to Shanghai in less than 45 minutes at an altitude of 800 miles. The planned accuracy of the Atlas as reported to Congress in 1959 is less than five miles at the 6,000 mile range. This past week the Air Force has successfully fired the Titan which is larger than the Atlas and has a 10,000 mile range. (This gives us two operational ICBM's.)

Missiles present hazards requiring health education and supervision on all personnel. The propellants (oxidizers and fuels) now in use beside the LOX (liquid oxygen) and hydrocarbons are chemicals such as anhydrous ammonia, liquid hydrogen (temperature -423°), amline, alcohols, chlorine trifluoride, ethylene oxide, fluorine, hydrazine, hydrogen peroxide, fuming nitric acid, and n-propylnitrate, to mention a few. You may recall the protective procedures used in laboratories when handling test tubes containing these toxic and caustic materials. We are, however, now engaged in handling tank carloads of the same.

The storage, transportation, cleaning of containers of these toxic compounds present a constant danger. Familiarity breeds contempt. This is where our military physician becomes health educator. Selectees must be taught safety and security.

The nuclear powered submarines, and particularly those such as the George Washington, designed to transport and fire the Polaris missile from a submerged position have increased the responsibilities of the physician assigned aboard. These navy medical officers have received graduate education both in radio biophysics and submarine officer's schooling.

Submariners, we are informed, receive less radiation when their nuclear powered sub is running submerged than they do when ashore. These "subs," however, present added problems associated with toxicity. Paint, paint remover, grease, oils, refrigerants, cigarettes, lighter fluid, carbon monoxide, carbon dioxide, all present need for constant surveillance when crews remain submerged for long periods (2 months or more) of time. The common cold, dermatitis and constipation, their prevention and care, still plague the submariner and his medical officer.

When Polaris missiles are carried aboard, additional problems will be encountered with the storage of propellants and war heads.

In the past 15 years, military medical officers have been schooled as to the problems of fallout radiation and thermal hazards associated with nuclear weapons. Many of us remember how often during World War II we medical officers were given instruction in chemical warfare hazards, and even a few lectures on bacteriological warfare.

Today, our planes transport nuclear war heads. The public press has reported several plane accidents involving such war heads. In these, the greatest hazard is blast and radiation contamination rather than detonation and fallout. Medical officers may, however, have to meet additional hazards associated with storage and transportation of these weapons.

Various predictions have been made as to the future of the nuclear powered aircraft, with its potential hazard to ground crew. Time alone will tell. We can expect, however, to have before long, nuclear powered portable power plants as a source of light, heat and power in areas where coal and oil are not readily available to turn our generators.

Regardless of the weapon or weapon system, military medical officers still will be expected to meet the constant challenge involved in "Maintain the Fighting Force," be it by preventive, clinical, rehabilitative, or research medicine. Initiative and dedication to our cause means safety for our fellow citizens and security for our nation.

We have all read of the selection of the astronauts to participate in project Mercury (man in orbit). It is true that the first such trips will be only three to four times around the earth for a time lapse of three to four hours. Nevertheless, many problems are encountered that are new

and not adaptable in every incident to laboratory experiments.

In discussing the Atlas, we spoke of the temperature being 5000° at time of launch. The acceleration is more than 40 G for many seconds. The astronaut must be in position to withstand such stress, yet he must have some type of escape mechanism in case of malfunction on the pad. Once in flight the problem of "weightlessness" must be duly considered. Temperature on the capsule side facing the sun may be several thousand degrees and, at the same time, on the side facing away from the sun a hundred degrees below zero. The living space must provide proper shielding from these temperature variants. As the capsule passes through the Van Allen magnetic field, shielding from electrons and neutrons becomes essential. Oxygen must be available (the nuclear powered subs have demonstrated the practicability of oxygen generators). All waste products must be stored, dehydrated and the water re-used. (Human sweat can become an irritant substance in a short period of time in a small, confined space). Carbon dioxide must be eliminated from the closed system.

Assuming, then, that our astronaut has had medical science and space engineers solve his problems, he now must trigger the mechanism to force his vehicle to return to the earth planet. Again, we are confronted with excessive G forces, escape mechanisms, buffetting, and extreme heat generated by re-entry into the earth's atmosphere, less than 20 miles to brake from 26,000 miles per hour (the speed required to orbit) to a safe landing speed.

Again, assuming that all has gone well, our astronaut now must be located and rescued from the earth's surface (landing or target area), no mean feat in itself.

If and when the astronaut has survived this, his family physician still will be needed to protect him from the banquet circuit, the Madison Avenue advertising agencies, Hollywood and the TV industry. Gastric ulcer, fatigue and nervous exhaustion well may prove more dangerous than all the missile and space vehicle medical and health hazards.

This common sense return to basic facts is to remind us of the intuition, clinical knowledge, humanitarian attitude and salty realism with which Dr. Paul Hawley and his three Navy medical colleagues met a crisis in the spring of 1931 in Nicaragua. The challenge is ours but, in this "space age," no greater than it was 30 years ago.

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## Weather and Conversation

It will be a sad day when we can no longer talk about the weather and speculate as to what will happen next. Indeed our conversation will undergo a revolution—what will we talk about instead?

Apparently, the hazard is real. C. G. Abbott of the Smithsonian Institution in a paper presented to the National Academy of Sciences and abstracted in *Science* points out that a family of regular harmonic periods of identical lengths in the sun's radiation and in weather has been discovered. By adding the harmonic periods, monthly departures from the normal precipitation for the years through 1967 are predicted for 32 cities.

Perhaps it will not be long before long-range weather forecasting will be so accurate for specific areas that we can plan picnics, planting, lawn watering and many other things well in advance with the certainty that the anticipated weather will arrive on schedule. Advantages are obvious; some of us old time weather sniffers, however, will suffer strong nostalgia.—Group Practice.

# The President's Page

## Improved Medical Care Goal of Committees

BEFORE I assumed the duties of the office of president of the West Virginia State Medical Association, I had received the written acceptance of each committee chairman to serve during my term of office. I was proud and pleased because of this concrete expression of complete cooperation. It has long been a tradition of our Association that it is a high honor to be asked to serve on one of our committees as chairman or member. Very few have taken this honor lightly. The work done by our committees is the "heart-beat" of our organization. The tremendous amount of time and effort given through the years by the members of our various working committees has paid off in improved medical care and services for our fellow West Virginians.

A recent example of the important contribution made by a committee was the participation of our Committee on Aging at the Second Governor's Conference on Aging held in Charleston, September 1-2. Drs. Lyle Gage and George Callender and members of the Association's Committee on Aging participated in this Citizen's Forum and all contributed greatly to the preparation of resolutions to be forwarded to the White House Conference in January, 1961.

Someone has said that "a committee is a group of important people who singly can do nothing and together can decide that nothing can be done." This is a false definition of the committees of the West Virginia State Medical Association.

In his address before our House of Delegates at The Greenbrier in August, Dr. E. Vincent Askey, president of the American Medical Association, said that the AMA has often been accused of having "anti-itis." This oftimes happens because we are reluctant to relate the positive things we do. Let's make our committee efforts this year positive and public.

It is high time that American medical men let the public know of the efforts going on in every community to improve hospital care and all related health services. This may help to allay the feeling on many fronts that if the AMA is agin' it, then we're for it! This same attitude was shown by the proponents of the Forand Bill who said that the doctors were against the Forand Bill because they were afraid it would hurt their pocketbooks before they had the good sense to find out what it would do to their own pocketbooks.

On other pages of this issue of *The Journal* you will find listed the names of the physicians who will be serving with me during the coming year. My selfish pride makes me yearn to make this a year of great accomplishment and dedicated service to our fellowmen. I cannot do this. Only the accomplishments of the committees can make this a fruitful and meaningful reality.

We lean heavily upon the experience and judgment of our past presidents. Through the years they have given generously of their time, sharing their experience and vast knowledge in all facets of our challenging responsibilities.

I have made a concerted effort to man the committees in roughly four geographic quadrants to aid communication and to save distances in travel to meetings.

I know that several committees are already at work. Indeed, many held meetings during the Convention in August. This will give greater continuity to the work of the Association. This early pooling of ideas and the setting up of goals for the year get us off to a good start. It is gratifying to observe such enthusiasm and interest on the part of committee chairmen and members. May the spirit continue and may all of us working together do credit to our noble profession.

John W. Hash

John W. Hash, M. D., President

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*Official Organ of the West Virginia State Medical Association*

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*Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.*

*Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.*


# EDITORIALS

## JOHN W. HASH, PRESIDENT

The axiom, "Experience is the Best Teacher," holds good for the medical profession as well as for most all other businesses and professions. The rise of Dr. John W. Hash to the presidency of the West Virginia State Medical Association is a case in point.

Doctor Hash has served efficiently as secretary and president of Kanawha Medical Society, and as vice president and president elect of the West Virginia State Medical Association. The experience he has gained by reason of this close tie-in with organized medicine will serve him well during his term of office as president of the state group. The Association, composed of over 1450 members, will not look to him in vain for guidance in their every endeavor during the next twelve months.

Energetic, efficient and experienced in the ways of administrative medicine, as well as successful as a general practitioner, Doctor Hash possesses all the qualities of a leader, and the membership of the Association will not find their confidence in him misplaced. Rather, when the year ends, we have no doubt that medical history will record that Doctor Hash has served faithfully and well as head of organized medicine in this state.

He is a worthy successor to Dr. J. C. Huffman, who retired from the office of president during the closing moments of the 1960 meeting at The Greenbrier secure in the knowledge that he had given his best for medicine. On behalf of all the members of the State Medical Association, we thank him for what he has done and extend con-

John W. Hash, M. D.

gratulations to Doctor Hash upon his elevation to the office of president. We feel that we speak for the entire membership when we extend to him best wishes for a successful term.

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**ATTENDANCE SPEAKS WELL FOR CONVENTION PROGRAM**

We would be remiss in our duty to the entire membership of the State Medical Association were we to fail to pay tribute to the members of the committee which arranged the scientific program for the 93rd Annual Meeting at The Greenbrier in August. The topics discussed by speakers of national reputation drew what is believed to be a record attendance for the usual three morning scientific sessions at The Greenbrier.

In the past, attendance has not been too heavy, due to the many other attractions at The Greenbrier; but even in the face of beautiful weather, members of the State Medical Association and guests turned out in great numbers to hear messages brought by speakers who were eminently qualified to discuss the topics assigned to them.

Our thanks go to the chairman, Dr. Seigle W. Parks of Fairmont, and the other members of the Program Committee, Drs. G. Thomas Evans of Fairmont, Kenneth G. MacDonald of Charleston, Theresa O. Snaith of Weston, and William A. Thornhill, Jr. of Charleston, for arranging such an attractive program.

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**CONGRATULATIONS TO THE AUXILIARY**

We take off our collective hats to the Auxiliary. This fine group of women succeeded in setting an all-time record for attendance at the Annual Meeting at The Greenbrier in August. At the close of the registration, it was found that attendance had reached a total of 242, nineteen over the previous high set in 1958.

All of the Auxiliary sessions were well attended, and the reports interesting and informative. Among the highlights of the convention were the addresses of Mrs. Robert R. Pittman, retiring president, Mrs. Clark K. Sleeth, incoming president, Mrs. William Mackersie, president of the AMA Auxiliary, and Mrs. John M. Chenault, president of the Southern Medical Auxiliary.

There was a large attendance of members of the Auxiliary at all of the scientific sessions of the State Medical Association, and this speaks well for the type of program arranged by the Program Committee.

More and more the Auxiliary is becoming interested in the problems of organized medicine so far as they pertain to administration and legislation. It is no secret that help when needed has been forthcoming from the members of this right arm of organized medicine, and especially has this been true during the fight against Forand-type legislation in Congress and support for bills sponsored by the Association in the Legislature.

Mrs. Pittman has ably demonstrated qualities of leadership during the past year, and the new president, Mrs. Sleeth, has already proved that she is a worthy successor.

To these two officers, as well as all the others elected at White Sulphur Springs in August, and to the heads of committees and officers of local auxiliaries we extend best wishes for another successful year.

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**MEDICAL SCHOOLS FACE ENROLLMENT PROBLEMS**

It has been pointed out by the Central Office of the Association of American Medical Colleges that for the third consecutive year the number of individuals applying to medical schools in the United States has decreased.

In the year 1956-57 there were 15,917 applicants, whereas in 1959-60 there were 14,951, a six per cent decrease. It is of interest, however, that the number of accepted applicants in 1956-57 was 8,263, but in 1959-60 there were 8,510, an increase of three per cent.

The greatest number of applicants to medical schools in the United States was during the period following World War II. For example, in 1949-50 there were 24,434. A part of this sharp increase was no doubt due to the G. I. Bill of Rights. In 1952-53 there was a noticeable drop.

The decrease thus far noticed in the number of applicants is of no grave concern, unless, of course, the trend continues or accelerates. A more alarming matter is, that though the number of college graduates has greatly increased (from 199,571 in 1956-57 to 257,000 in 1958-59), fewer students are applying for entrance into medical schools. It appears that many students are attracted to other fields, such as nuclear physics, mathematics, chemistry and engineering. This shift of interest may be just a temporary trend, although it is too early to predict.

In the final analysis, the most important factor is the quality of the students applying. As emphasized in an editorial in a recent issue of *The Journal* (September 1960), physicians should not only encourage desirable students to enter the

study of medicine, but aid and guide them in their pre-medical years. Furthermore, loan funds should be made available so that every capable and deserving student in the state may pursue the course in medicine, and not be kept out because of lack of funds.

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**A GOOD PROGRAM**

The Ophthalmologists Scholarship Fund of the Guild of Prescription Opticians of America, Inc., has announced the bestowing of six additional scholarships to young physicians who are beginning their residency training in ophthalmology. Those named in this general area are Drs. Junius E. Crowgey, Roanoke, Virginia, at the University of Virginia Hospital, Charlottesville, Virginia, and William R. Harris, Henderson, North Carolina, at the Ohio State University Hospital, Columbus, Ohio.

Five years ago the Guild of Prescription Opticians of America began this program. It provides for eighteen Fellowships for residents in ophthalmology on a nationwide basis. Each Fellowship is for a total of $1800 payable in monthly stipends over the period of the three-year residency.

We cannot help but feel that the Guild of Prescription Opticians is entirely correct in this program. It puts that organization in the position of furthering eye work by the medical profession rather than by opticians. These scholarships are given out on competitive examination and are decided upon by a committee of ophthalmologists rather than opticians.

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**NATION FIGHTS NOVOTEITIS**

Prominent leaders in American medicine have again warned all America against a possible epidemic of Novoteitis (No-vote-itis), a disease affecting many adult Americans. These same leaders point out that although vast sums have been spent on research and education since the last outbreak in 1956, there is always a possibility of a flare-up. Because of the nature of this peculiarly American disease (of which too little is known), it can appear in many areas of the land at the same time. Although of short duration, the epidemic often leaves the nation with serious after effects.

Researchers have found, however, that immunity from novoteitis is obtained through constant vigilance. They have also determined that the disease attacks both males and females beginning at the 21-year level, although one state reported cases among 18 year olds.

During the past four years, the study showed that novoteitis is no respector of personalities, as it strikes at all levels of the nation's income groups. However, the facts show that a large number of cases occur among members of the professions, with doctors of medicine being among those often afflicted.

Temporary paralysis of the hand and loss of forward motion in the feet, both characterize the disease. Strangely enough, the diagnoses have been more readily made by political observers than by busy men of American medicine.

The implications of the above allegory are many. To the practicing profession, it is both a challenge and an indictment. To the medical student it can mean just one thing—the development and use of the strongest antibiotic known to politics—the individual doctor's vote.

Only when physicians-to-be and physicians-who-are accept their full and complete responsibilities of American citizenship, can there be hope of relief from the ravages of novoteitis—a disease welcomed by self-perpetuating politicians to the detriment of the people at large.—*The New Physician.*

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**Importance of Alumni Organizations**

The noblest aspects of man's character are reached when he is able to dissociate himself from selfish interest and think and act for the common good.

Medical education must concentrate to a large extent on the education of the individual to develop competence in medical practice. This education can be used in a way to bring maximum benefits to the individual with little consideration for many in society that need assistance and are unable to care for themselves.

The physician's obligation to society and to the improvement of medical practice through education and research are basic concepts of the Hippocratic Oath. Medical alumni organizations are one of the more important groups that physicians have developed for objective evaluations of medical education, and to assist those charged with conducting the programs in the medical schools and hospitals.

For alumni groups to reflect more than the thinking of a few individuals, it is important that they seek to engage the interest and participation in alumni activities of every graduate.

At graduation time, it is of greatest importance that the senior class be indoctrinated and welcomed into the alumni activities and organizations. Human progress is dependent upon the need for living as individuals in a society.—William S. Stone, M. D., in Bulletin, School of Medicine, University of Maryland.

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Oaks are the true conservatives; They hold old leaves till summer gives a green exchange.—Roy Helton.

# GENERAL NEWS

## Dr. John W. Hash Assumes Presidency Of State Medical Association

The 93rd Annual Meeting of the West Virginia State Medical Association came to a fitting close on Saturday afternoon, August 27, with the installation by Dr. E. Vincent Askey of Los Angeles, president of the American Medical Association, of Dr. John W. Hash of Charleston as president. He succeeds Dr. J. C. Huffman of Buckhannon, who will serve during the coming year as chairman of the Council.

Doctor Hash was named vice president in 1958 and president elect at the annual meeting in 1959, and as such has served as a member of the Council during the past two years.

Dr. John W. Hash of Charleston, right, was installed as president of the West Virginia State Medical Association by Dr. E. Vincent Askey of Los Angeles, California, president of the American Medical Association.

### Dr. D. E. Greeneltch Named President Elect

Dr. D. E. Greeneltch, who has served as vice president during the past year, was named president elect. He will be installed as president at the 94th annual meeting at The Greenbrier in August, 1961.

Dr. Lawrence J. Pace of Princeton, who has served during the past four years as a member of the Council, was elected vice president. He has also served as chairman of the key Committee on Mental Health during the past year.

Dr. Daniel N. Barber of Charleston was reelected treasurer, a post he has held since 1958, when he was named to fill the unexpired term of his brother, Dr. T. Maxfield Barber, who had served as treasurer for over thirty years.

Dr. George F. Evans of Clarksburg, who has served during the past year as chairman of the Council, will serve as Councillor-at-Large during the Association year 1960-61.

### Four New Members of the Council

Four new members of the Council were elected as follows:

First district, Paul P. Warden, Grafton; third, R. V. Lynch, Jr., Clarksburg; fifth, Ward Wylie, Mullens; and sixth, Theodore P. Mantz, Charleston.

Dr. Seigle W. Parks of Fairmont, L. E. Neal of Clarksburg, L. J. Pace of Princeton and William L. Cooke of Charleston retired as members of the Council. They were not eligible for reelection, having served two consecutive terms.

Dr. S. Elizabeth McFetridge of Shepherdstown and Dr. C. L. Goodhand of Parkersburg were reelected as members of the Council from the second and fourth districts, respectively. They had served but one term and were eligible for reelection.

### Hold-Over Members of Council

Hold-over members who will serve during 1960-61 are as follows:

First district, Richard E. Flood, Weirton; second, J. C. Pickett, Morgantown; third, C. R. Davisson, Weston; fourth, Albert C. Esposito, Huntington; fifth, Harold Van Hoose, Man; and sixth, Clyde A. Smith, Beckley.

### Dr. Hoffman Reelected AMA Delegate

Dr. Charles A. Hoffman of Huntington was reelected AMA delegate from West Virginia, and Dr. J. C. Huffman of Buckhannon, alternate. Each will serve another two-year term beginning January 1, 1961. Dr. Frank J. Holroyd of Princeton is the hold-over AMA Delegate and Dr. Thomas G. Reed of Charleston, the hold-over alternate.

### President Long Active in Organized Medicine

The new president, Doctor Hash, was born at Pageton, McDowell County, son of Mr. and Mrs. V. W. Hash, who now reside at Marion, Virginia. He was graduated from Elkhorn High School in McDowell County and received A. B. and B. S. degrees from West Virginia University. In 1939, he received his M. D. degree from the Medical College of Virginia.

Doctor Hash interned at Charleston General Hospital and at the completion of his internship was named head of the out-patient department, a post he held until he entered the armed forces in 1942.

He served for more than two and a half years as Assistant Chief of Medicine with the 234th General Hospital in India, being released with the rank of Major. He has engaged in general practice at Charleston since his return from the service.

He is now chief of general practice at Charleston Memorial Hospital and is currently serving as president of the Alumni Association of the WVU School of Medicine.

He was president of Kanawha Medical Society in 1955 and was its secretary, 1948-49.

He married the former Beulah Lawler, and they have two sons, John, a junior in pre-medicine at Duke University, and Richard, a sophomore in pre-dentistry at West Virginia University.

### President Elect Native of Ohio

The president elect, Dr. Delmas E. Greeneltch, is a native of Barnesville, Ohio. He was graduated from Ohio State University with an A. B. degree in 1929 and received his M. D. degree from the University of Louisville School of Medicine in 1935.

He served his internship at Louisville General Hospital and served a residency there, 1936-38. He was licensed to practice in West Virginia in 1941. His specialty is anesthesia, and he is certified by the American Board of Anesthesiology.

He is a member of the Ohio County Medical Society, and has served as president, vice president and secretary of that Society. He was a member of the Council from the First District, 1956-58, and was vice president of the West Virginia State Medical Association, 1959-60. He will serve as president elect during the current Association year.

### Resolutions Committee Active

The Resolutions Committee, which was made a standing committee by an amendment to the By-Laws in 1959, held an open hearing on the two resolutions lodged with the executive secretary at least two weeks prior to the first day of the meeting. Courtesy resolutions prepared and introduced by unanimous consent by Dr. James S. Klumpp were adopted unanimously.

The report of the committee which appears elsewhere in this issue of *The Journal*, includes the resolutions as introduced and a report of the action thereon by the House of Delegates. One of the resolutions provides for the levying of a voluntary assessment of $10 per dues-paying member for the American Medical Education Foundation.

### Action on Proposed Amendments

The amendment to the Constitution proposed in 1959 which would provide for the expansion of the membership in the House of Delegates to include a delegate from each council-approved section and affiliated association and society was defeated at the first session of the House of Delegates.

An amendment to the By-Laws offered at the first session on Wednesday, August 24, by Dr. James P. McMullen of Wellsburg, Chairman of the Committee on Constitution and By-Laws, was adopted unanimously at the second session on Saturday afternoon. The amendment follows:

Chapter VI, Section 2. Amend the Section by deleting the words "President Elect" in line four and inserting in lieu thereof the words "Vice President."

(The effect of the amendment would be to provide for the succession of the vice president to the presidency in the event of the death, resignation or removal of the president, or his incapacity to serve).

**Dr. J. C. Huffman of Buckhannon, right, immediate past president of the State Medical Association, receives president's charm and plaque from Dr. George F. Evans of Clarksburg during the first session of the House of Delegates on Wednesday evening, August 24.**

**In the other photo, Dr. D. E. Greeneltch of Wheeling, who was named president elect of the State Medical Association, is shown with two past presidents, Dr. J. P. McMullen of Wellsburg, left, and Dr. Robert J. Reed, Jr., of Wheeling.**

### 'West Virginia Day' at Medical Center

At the first session of the House on August 24, Dr. Carl B. Hall of Charleston, chairman of the Committee on Medical Education and Scholarships, called attention of the members to the recommendation of his committee, as carried in his annual report published in the August issue of *The West Virginia Medical Journal*, that the State Medical Association consider establishing a "West Virginia Day" at the University Medical Center.

In the report it was recommended that an appropriate program be arranged by the committee in cooperation with the School of Medicine, and that a speaker be provided for the occasion by the State Medical Association.

On motion of Doctor Hall, the House of Delegates unanimously approved the establishment of a "West Virginia Day" at the University.

### Addresses by Drs. Huffman and Askey

Dr. J. C. Huffman, the retiring president, delivered his Presidential Address at the first session of the House on Wednesday evening. The president of the American Medical Association, Dr. E. Vincent Askey of Los Angeles, California, was the guest speaker before the final session of the House on Saturday afternoon.

Dr. Bernard S. Clements of Matoaka, West Virginia's "General Practitioner of the Year" for 1960, is congratulated by Dr. J. C. Huffman during the final session of the House of Delegates on Saturday afternoon, August 27.

The complete text of Doctor Huffman's address appears elsewhere in this issue of *The Journal*, beginning on Page 371.

### Plaque Presented to GP of the Year

At the second session of the House, a plaque was presented by the President to Dr. Bernard C. Clements of Matoaka who had previously been named by the Council as "West Virginia's General Practitioner of the Year."

The recipient accepted the plaque and voiced his deep appreciation for the honor that had been bestowed upon him. He recounted some of his experiences during the 53 years he has engaged in general practice, and called attention to the fact that he is 78 years of age and still actively engaged in practice.

### 1961 Meeting at The Greenbrier

At the final session of the House of Delegates on Saturday, August 27, it was ordered by the unanimous vote of the delegates present that the 94th Annual Meeting of the State Medical Association be held at The Greenbrier in 1961. The meeting is scheduled for August 24-26.

### Scholarship Recipient Introduced to House

Harry Glenn Buchanan of Gilbert, Mingo County, was presented to the House at the second session on Saturday afternoon by Dr. Carl B. Hall of Charleston, chairman of the Medical Scholarships Committee, as the recipient of the 1960 Medical Scholarship Award.

The recipient is the 21-year-old son of Mr. and Mrs. Arthur B. Buchanan. He is a graduate of Gilbert High School and completed his pre-medical training at Berea College in Kentucky. He is enrolled as a freshmen in the WVU School of Medicine. "Glenn" is the third student to receive a medical scholarship under the program which became effective in 1958. Larry Hemmings of Charleston was the first student to receive the award, and Terry T. Tallman of Alma, Tyler County, was the recipient in 1959.

### Registration Again Exceeds 800

The overall registration for the meeting was 805, five more than in 1959. The physician registration was 449, as compared with 463 in 1959 and 489 in 1958.

### All-Time High Registration by Auxiliary

An all-time high was set by the Auxiliary, the total registration being 242 as compared to 186 last year. The previous record registration was 223, reached in 1958. The total registration for exhibitors and other guests was 114.

### 1961 Meeting at The Greenbrier

Just before adjournment on Saturday afternoon, August 27, the House voted unanimously to return to The Greenbrier for the 94th Annual Meeting in 1961. The Council fixed August 24-26 as the date for the meeting next year.

### Reception for Association Officers

A reception for the officers of the State Medical Association was held on the Chesapeake Hall Terrace on Saturday evening. In the receiving line were officers of the Association and Auxiliary, and Dr. and Mrs. E. Vincent Askey. More than 400 persons including physicians and their wives, guests and exhibitors attended the party.

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Just when you're beginning to think pretty well of people, you run across somebody who puts sugar on sliced tomatoes.—Will Cuppy.

## MLB Licenses 40 Physicians as Result Of July Examinations

The Medical Licensing Board has released a report concerning examinations held in Charleston, July 11-13, 1960. The report shows that 40 physicians have been licensed to practice medicine in West Virginia, 22 by examination and 18 by reciprocity.

The following physicians were licensed by examination:

Cooley, William Shelley, Glen Rogers
Gimenez, Ezequiel Emilio, Huntington
Hernandez, Leopoldo, Madison
Jones, Archbold Marion, Jr., Cincinnati, Ohio
Lee, Chuan Hsiang, Montgomery

Rogers, Lee Frank, Vienna
Richey, Drake, Wellsburg
Antalis, James Peter, Wheeling
Appling, John Morgan, Bluefield
Bekenstein, William Leon, Richmond, Va.

Blumenthal, Harold Leslie, Cleveland, Ohio
Bowers, Karl Douglas, Manor Beach, Va.
Fearnow, Ronald Grayson, Charles Town
Gainer, James Vincent, Jr., Philadelphia, Pa.
Ghaphery, Alfred David, Wheeling

Harris, Robert Miller, Richmond, Va.
Kendall, Juneus Frederick, Charleston
Leadbetter, Robert Lewin, Charleston
Mangus, Jimmie Lee, Charleston
Powers, James Edward, Richmond, Va.
Stacks, Donald Pressley, Charlottesville, Va.
Traugh, George Holton, Philadelphia, Pa.

The following physicians were licensed by reciprocity:

Craig, Harry Leroy, Whitesville
Edwards, David Everett, Keyser
Fagerstrom, Charles Daniel, Fairmont
Fisher, Albert Joseph, Wheeling
Gelford, Gerald Jerome, Webster Springs

Guy, George Henry, Union
Kravitz, Herbert Melvin, Charleston
Montgomery, Terryl Brook, Williamson

Pavlick, Theodore J., Dearborn, Michigan
Perry, Irvin Samuel, Charleston

Reinhard, Melvin Charles, Jr., Elkins
Scarcella, James Vincent, Charleston
Schaefer, John Joseph, Charleston
Steiner, William Edward, Beckley
Trier, Herbert Paul, Morgantown

Whitworth, Fuller Barnard, Cumberland, Md.
Zimmermann, Bernard, Morgantown
McCune, Robert, Clarksburg

The fall meeting of the Board will be held in Charleston on October 3, 1960, for the purpose of examining applicants to practice medicine in this state.

## Dr. Halvard Wanger Heads 1961 Program Committee

Dr. Halvard Wanger of Shepherdstown has been named by Dr. John W. Hash of Charleston, president of the State Medical Association, as chairman of the committee which will arrange the program for the 94th Annual Meeting at The Greenbrier, August 24-26, 1961.

The other members of the committee are Drs. Hu C. Myers of Philippi and Thomas H. McGavack of Martinsburg.

## Dr. Murry Named to County Offices

Dr. J. H. Murry of Gary has accepted appointment as coroner of McDowell County. He succeeds Dr. J. .A Bennett, who recently moved to Columbia, South Carolina.

Doctor Murry has also accepted appointment as health officer for McDowell County, a post previously held by Doctor Bennett.

Dr. John W. Hash of Charleston is shown with his family at The Greenbrier following his installation as president of the West Virginia State Medical Association. Left to right, Doctor Hash, John, a junior in pre-medicine at Duke University, Mrs. Hash, and Richard, a sophomore in pre-dentistry at West Virginia University.

## Pre-Convention Meeting of Council Draws Full Attendance

The Pre-Convention meeting of the Council which was held at The Greenbrier in White Sulphur Springs on August 24 drew a one-hundred per cent attendance of members. In addition, chairmen and members of several committees were present.

### Blue Cross-Blue Shield Report

The Medical Economics Committee, headed by Dr. James S. Klumpp, submitted a report in which certain recommendations were made concerning out-patient coverage by Blue Cross-Blue Shield plans. It was brought out that each member of the State Medical Association had been furnished a copy of Blue Cross-Blue Shield contracts, with specified benefits, and it was suggested that the lead taken by several component societies in devoting one meeting each year to Blue Cross-Blue Shield matters be adopted generally so that facts concerning the plans could be discussed in detail.

It was further recommended that out-patient diagnostic services should be provided under the direction of the family physician and that such services should be covered by Blue Shield.

It was further recommended that provision be made for a deductible contract which would discourage over-utilization.

### Organization of Joint Council Approved

The organization of a "Joint Council to Improve the Health Care of the Aged" was discussed in detail by Dr. E. Lyle Gage of Bluefield, chairman of the Committee on Aging.

Doctor Gage said that such a Council has already been set up in about 30 states, and that a temporary organization had been effected at a meeting held in Charleston on June 22, 1960. Representatives were present from the West Virginia Hospital Association, the West Virginia Dental Society, the West Virginia Nursing Home Association, and the State Medical Association. He reported that at the meeting he had been named temporary chairman, and Charles Lively temporary secretary.

Doctor Gage said that the organization of a Joint Council had been approved formally by all the groups represented at the meeting with the exception of the State Medical Association and the State Dental Society.

(The State Medical Association was notified officially early in September that the West Virginia State Dental Society had agreed to participate in the organization of the Council).

He recommended that the State Medical Association join with the other groups in the formation of the Council.

Several members discussed the project and it was ordered unanimously that the State Medical Association participate as an active agent in the formation of the proposed Council. It was agreed further that in the event the organization is completed, Dr. George R. Callender, Jr., of Charleston, and Dr. E. Lyle Gage of Bluefield are to represent the West Virginia State Medical Association.

### Social Security Report

Dr. Charles A. Hoffman, chairman of the Insurance Committee, submitted an interesting detailed report with reference to a recent Social Security survey conducted through the headquarters offices at Charleston. (The report appears elsewhere in this issue of *The Journal*).

### Fees for Surgical Assistants

Following a report by Dr. Charles M. Scott of Bluefield concerning the problem of fees for surgical assistants under the Medicare Program, his recommendation that such fees be covered in the By-Laws of each hospital in the state was approved.

### Determination of Alcoholic Content in Blood

The matter of the withdrawal of blood for the purpose of determining alcoholic content was given consideration by the Council following an oral report by Dr. Frank J. Holroyd, chairman of the Legislative Committee. He discussed the methods now being used by the other states in handling this matter and suggested that probably the best way to handle the situation in West Virginia would be to request prosecuting attorneys over the state to draft a bill for introduction in the Legislature with the assurance that the State Medical Association would cooperate in seeking its passage.

The Council directed the Legislative Committee to consider the proposal with members of the Medico-Legal Committee and then report at the next meeting.

### Standard Form for Insurance Claims

The matter of the adoption of a standard form for reporting insurance claims was referred to the Insurance Committee for study and report back at a future meeting.

### Health and Medical Activities Under Single Head

The following resolution offered by Dr. Charles A. Hoffman was adopted and ordered referred to the Legislative Committee for necessary action:

BE IS RESOLVED BY THE COUNCIL OF THE WEST VIRGINIA STATE MEDICAL ASSOCIATION, That it is to the best interest of the state and its citizens that all of the health and medical activities of the state be located within one agency so as to assure proper coordination and prevent overlapping of effort and expenditures; and,

BE IT FURTHER RESOLVED, That the West Virginia State Medical Association hereby memorializes the West Virginia Legislature to enact legislation to provide for

1. The transfer to the State Department of Health of the management, direction, control and government of Denmar, Berkeley Springs, Pinecrest, Hopemont and all other sanatoria for the treatment of tuberculosis and chronic diseases, together with the emergency hospitals at Fairmont and Welch;

2. The transfer of the budget of each institution to the State Department of Health, each to be earmarked for its own institution;

3. The authorization of the West Virginia Board of Health, with the advice of the State Director of Health, to assign the general supervision of these institutions to applicable divisions, bureaus, administrative sections or groupings within the State Department of Health; and,

4. The selection and appointment of the personnel of the institutions so transferred in the same manner under the State Merit System as other personnel of the State Department of Health.

**Mental Health Resolutions Adopted**

The following resolutions prepared by the Committee on Mental Health offered by the chairman, Dr. L. J. Pace, were adopted unanimously.

No. 1. Resolved, That the Mental Health Committee recommends that the present laws applying to epileptics be revised so as to remove the undesirable stigmata and legal disabilities from which epileptics now suffer.

No. 2. Resolved, That the Mental Health Committee recommends that the law requiring that the director of the Department of Mental Health be a legal resident of the State of West Virginia at the time of his appointment be changed so that such a requirement will not be necessary. The method or methods of accomplishing this change should be left to our State Legislature.

No. 3. Resolved, That the Mental Health Committee believes that the present laws regarding the commitment of the mentally ill should be revised. The members of this Committee would be pleased to counsel with the Director of the Mental Health Department in the accomplishment of this objective.

The following officers and members of the Council were present at the meeting: Dr. George F. Evans, Clarksburg, Chairman; Dr. Charles A. Hoffman, Huntington, Councillor at Large; Dr. J. C. Huffman, Buckhannon, President; Dr. John W. Hash, Charleston, President Elect; Dr. D. E. Greeneltch, Wheeling, Vice President; Dr. Daniel N. Barber, Charleston, Treasurer; and Drs. Seigle W. Parks, Fairmont; Richard E. Flood, Weirton; S. Elizabeth McFetridge, Shepherdstown; J. C. Pickett, Morgantown; L. E. Neal, Clarksburg; C. R. Davisson, Weston; Charles L. Goodhand, Parkersburg; Albert C. Esposito, Huntington; L. J. Pace, Princeton; Harold Van Hoose, Man; William L. Cooke, Charleston; and Clyde A. Smith, Beckley; and Mr. Charles Lively, Executive Secretary, and Mr. William H. Lively, Executive Assistant.

The meeting was also attended by Dr. James S. Klumpp of Huntington, chairman of the Medical Economics Committee; Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. Walter E. Vest of Huntington, Editor of *The Journal*; Dr. N. H. Dyer of Charleston, State Director of Health; Dr. John D. H. Wilson of Clarksburg, member of the Medical Economics subgroup on DPA-Compensation; Dr. Charles M. Scott of Bluefield, member of the Medical Economics subgroup on VA-Medicare; Dr. E. Lyle Gage of Bluefield, chairman of the Committee on Aging; and Dr. L. Dale Simmons of Clarksburg, member of the DPA Medical Services Advisory Council.

## Medicine The Universal Language

The sympathy, generosity and exceptional skill of the American doctor and surgeon are legendary throughout the world. And medicine has been called the universal language. Wherever men talk about the problems of the sick and disabled, they speak a common language.—U. S. Senator John Sparkman in Journal, Med. Assn., State of Alabama.

## PG Courses on Diseases of the Chest To Be Sponsored by ACCP

Two postgraduate courses on diseases of the chest, sponsored by the American College of Chest Physicians, will be held in October and November, 1960. Announcement of the courses has been made by Dr. J. Winthrop Peabody of Washington, D. C., Chairman of the ACCP's Council on Postgraduate Medical Education.

The 15th Annual course, "Clinical Cardiopulmonary Physiology," will be held at the Sheraton Towers Hotel in Chicago, October 24-28. Arrangements for the course are being made under the co-chairmanship of Dr. Albert H. Andrews, Associate Clinical Professor of Bronchoesophagology, University of Illinois College of Medicine, and Dr. Edwin R. Levine, Assistant Professor of Clinical Medicine, Chicago Medical School.

The 12th annual course, "Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs," will be held at the Park Sheraton Hotel in New York City, November 14-18. Arrangements for this course are being made by Dr. Edgar Mayer, Clinical Professor of Medicine, New York University Postgraduate Medical Center; Dr. Alfred S. Dooneief, Lecturer in Medicine, Columbia University College of Physicians and Surgeons; and Dr. Emil A. Naclerio, Chief, Thoracic Surgical Services, Harlem and Columbus Hospitals, New York City.

Tuition for each five-day course will be $100 including round-table luncheon discussions.

Additional information concerning the courses may be obtained by writing Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 E .Chestnut Street, Chicago 11, Illinois.

## W. Va. Chapter, AAGP, To Sponsor Symposium in Morgantown

A symposium on the "Medical and Surgical Treatment of Cardiovascular Diseases," presented by four Pittsburgh physicians, will be held at the Medical Center in Morgantown on Sunday, October 9. The one-day meeting will be sponsored by the West Virginia Chapter of the American Academy of General Practice and Eli Lilly and Company.

Dr. J. Keith Pickens of Clarksburg, president of the Chapter, announced that the meeting will be called to order at 10 A. M., with adjournment scheduled for 1 P. M. The speakers and their subjects will be as follows:

"Recent Advances in Cardiology."—Frank Concilus, M. D.

"The Value of Cardiac Catheterization."—Stephen Zubritzky, M. D.

"Problems of Mitral Valve Surgery."—Robert Cartwright, M. D.

"The Surgical Treatment of Complete Heart Block." —William B. Ford, M. D.

Members of the American Academy of General Practice will be granted 4½ hours Category One Credit for attendance at the one-day meeting.

## Sections and Affiliated Societies Elect Officers for 1960-61

A majority of the sections and affiliated societies and associations of the West Virginia State Medical Association held scientific and business sessions in connection with the 93rd Annual Meeting at The Greenbrier, August 25-27.

Several prominent physicians and surgeons appeared on these programs which were held during afternoons of the meeting. The guest speakers on the general scientific program also participated actively and, in several instances, appeared as speakers before more than one group.

### Sections

The following is a list of officers of sections who will serve during the coming year:

**Internal Medicine:** E. L. Crumpacker, White Sulphur Springs, President; and Richard V. Lynch, Jr., Clarksburg, Secretary.

**W. Va. Academy of Oph. and Otol.:** John A. B. Holt, Charleston, President; Albert C. Esposito, Huntington, President Elect; William K. Marple, Huntington, Vice President; and W. W. McKinney, Beckley, Secretary-Treasurer.

**Orthopedic Surgery:** George R. Callender, Jr., Charleston, President; Earl A. McCowen, South Charleston, Vice President; and Lawrance S. Miller, Morgantown, Secretary-Treasurer.

**W. Va. Association of Pathologists:** Werner A. Laqueur, Beckley, President; David B. Thornburgh, Parkersburg, President Elect; and Grover B. Swoyer, Charleston, Secretary-Treasurer.

**West Virginia Pediatric Society:** Grover C. Hedrick, Jr., Beckley, President; Thomas G. Folsom, Huntington, Vice President; and W. W. Currence, South Charleston, Secretary-Treasurer.

**Surgery:** Charles E. Staats, Charleston, President; and R. T. Linger, Charleston, Secretary.

**Urology:** B. B. Richmond, Beckley, President; and Thomas B. Baer, Bluefield, Secretary.

### Associations

The following is a list of officers of affiliated associations and societies who will serve during the coming year:

**W. Va. State Society of Allergy:** Marshall J. Carper, Charleston, President; M. D. Reiter, Wheeling, Vice President; and Merle S. Scherr, Charleston, Secretary-Treasurer.

**W. Va. Society of Anesthesiologists:** Logan W. Hovis, Parkersburg, President; Newman H. Newhouse, Charleston, Vice President; and Harry S. Weeks, Jr., Wheeling, Secretary-Treasurer.

**West Virginia Diabetes Association:** Marion F. Jarrett, Charleston, President; Thomas H. McGavack, Martinsburg, President Elect; Delmer J. Brown, Parkersburg, Vice President; and William C. Revercomb, Charleston, Secretary-Treasurer.

**W. Va. Ob. and Gyn. Society:** John T. Chambers, Charleston, President; Fred H. Dobbs, Charleston, Vice President; and A. J. Villani, Welch, Secretary-Treasurer.

## Annual Mid-West Forum on Allergy In Pittsburgh, Oct. 22-23

The Fourth Annual Meeting of the Mid-West Forum on Allergy will be held at the Penn-Sheraton Hotel in Pittsburgh, October 22-23, 1960, with the Pittsburgh Allergy Society as host.

The following scientific program will be presented at the meeting:

**Saturday, October 22**

"Bronchial Asthma."—Max Samter, M. D.

"Management of Infection in Asthma."—Abraham I. Braude, M. D.

"Chronic Urticaria."—Panel Discussion with Drs. Kenneth P. Mathews, John H. Mitchell, Louis Tuft, and Robert J. Shoemaker, as panelists.

"Auto-Immune Glandular Disease."—Jack D. Myers, M. D.

"Drug Allergy."—Panel Discussion with Drs. Leo H. Criep, Carl E. Arbesman, Stanley F. Hampton, and John M. Sheldon, as panelists.

**Sunday, October 23**

"Physiological and Clinical Consequences of Respiratory Obstruction."—Eugene D. Robin, M. D.

"Repository Therapy."—Panel Discussion with Drs. Samuel M. Feinberg, Ethan Allan Brown, Murray Dworetzky, Sidney Friedlaender, Lawrence J. Halpin, Leo H. Criep, Mary H. Loveless, and Carl E. Arbesman, as panelists.

Full information concerning the program, together with reservation card for the meeting and hotel accommodations will be mailed upon request addressed to Philip Blank, M. D., Publicity Chairman, Mid-West Allergy Forum, 3028 Brownsville Road, Brentwood, Pittsburgh 27, Pennsylvania.

## Dr. C. A. Hoffman Panelist at AUA Mid-Atlantic Section Meeting

The Annual Meeting of the Mid-Atlantic Section of the American Urological Association will be held at the Hotel Dennis in Atlantic City, October 12-15.

The scientific program will feature a panel moderated by Dr. Rubin Flocks. The panelists will be Drs. Edgar Burns, John Lattimer, and Robert Lich, Jr. Dr. Robert Carter, professor of pediatrics at the University of Iowa Medical School, will also sit as a member of the panel.

Dr. Charles A. Hoffman of Huntington, past president of the Mid-Atlantic Section, will serve on another panel involving socio-economics in many of its phases, including national forces and influences, pre-paid medical care plans, fee scale problems, public relations, and a look into the future.

Dr. Donald Stubbs will be the lead-off man, moderator, and discussion leader. He is well informed in the political, bureaucratic and practical administrative aspects of pre-paid medical care plans. He is currently director of the National Association of Blue Shield Medical Care Plans.

Dr. James W. Lane of Charleston is one of the eight physicians who has been nominated for active membership in the AUA.

*93rd Annual Meeting*

# Guest Speakers

(Identifying Notes on Page 402)

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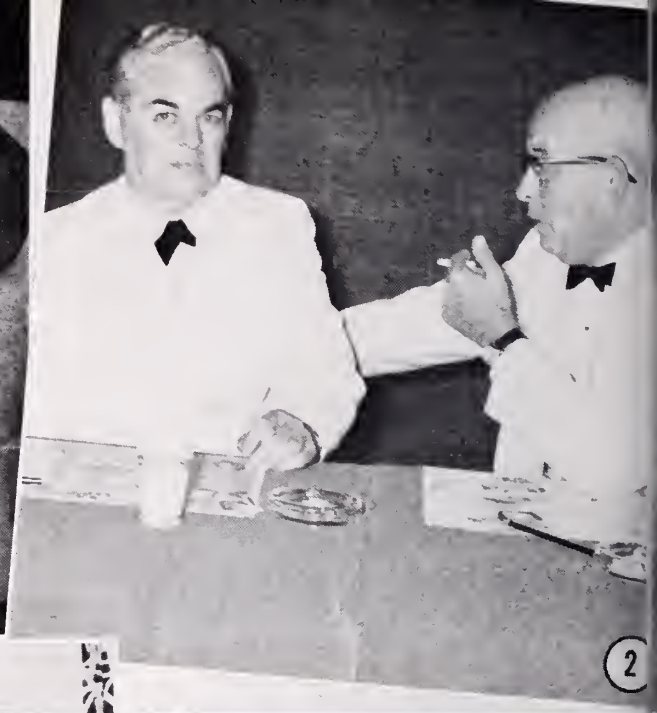

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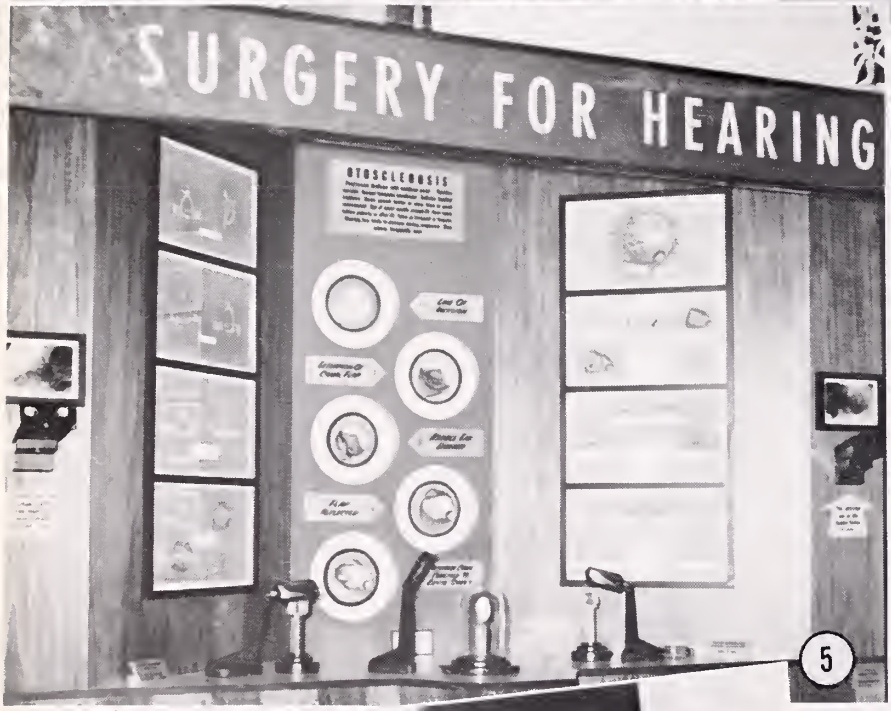


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# CAMERA HIGHLIGHTS

*93rd Annual Meeting*

WEST VIRGINIA STATE MEDICAL ASSOCIATION

The Greenbrier

Aug. 25-27, 1960

(Identifying Notes on Following Page)

## Dr. Gerrit Willem Hendrik Schepers To Speak Before B-R-T

Dr. Gerrit Willem Hendrik Schepers, a native of the Union of South Africa but now a citizen of the United States, will be the guest speaker before the Barbour-Randolph-Tucker Medical Society at a dinner meeting which will be held at the Elkins Country Club on Thursday evening, November 17, at six-thirty o'clock. His subject will be "Pathology of Lung Diseases."

Doctor Schepers has filled faculty posts at the University of Witwatersrand, Johannesburg, and the University of Pretoria. His work in this country has been with the Commonwealth Fund, New York City; Pulmonary Disability Committee, Department of Mines; Saranac Laboratories, Saranac Lake, New York; Trudeau Foundation, Saranac Lake; and the E. I. du Pont de Nemours & Company, Wilmington, Delaware.

The committee in charge of arrangements has extended a cordial invitation to all interested West Virginia physicians to attend the meeting. Further information concerning the meeting may be obtained by writing Dr. J. E. Martin, Jr., The Golden Clinic, Elkins.

## Vocational Rehabilitation Division Receives National Recognition

The State Vocational Rehabilitation Division restored 3,023 disabled persons to jobs during the past fiscal year and in so doing the Division won the No. 1 spot in national rehabilitation standings.

Announcement of the West Virginia top standing was made by Miss Mary E. Switzer, director of the federal office of vocational rehabilitation, in a telegram to Governor Cecil H. Underwood which stated in part, "your state's record is 154 rehabilitations per 100,000 population. This figure has never been attained before. This is the highest in West Virginia's history."

F. Ray Power, Director, said that placing first in the nation for the 1959-60 fiscal year climaxed a 12-year period in which West Virginia had ranked near the top in state rehabilitation programs. The Division won for West Virginia the national rank of second for the 1958 and 1959 fiscal years.

National rankings are determined by the Office of Vocational Rehabilitation on the basis of the number of disabled persons rehabilitated per 100,000 of population.

Mr. Power said all facets of the Division case services program showed significant increases over the 1959 total. Referrals increased by 415 to a new high of 9,001, and of these, 4,849 were accepted for services during the year. The acceptance-to-referral ratio for the year was 54 per cent, a gain of three points over that of the previous year.

## Mental Health Meeting in Chicago

The seventh annual Conference of Mental Health Representatives of State Medical Associations, sponsored by the Council on Mental Health of the American Medical Association, will be held at the Drake Hotel in Chicago, January 20-21.

## Greenbrier Pictorial

(See Preceding Pages)

### Guest Speakers

(1) Dr. Charles B. Jolliffe, vice president and technical director of the Radio Corporation of America (center), is shown with Drs. J. C. Huffman, left, and Seigle W. Parks, chairman of the Program Committee.

(2) Dr. G. Thomas Evans of Fairmont (center), a member of the Program Committee, with Drs. Vincent J. Collins of New York City and Roger B. Scott of Cleveland.

(3) A Symposium on Pyelonephritis was presented at the first general scientific session. Participants included, left to right, Drs. Grover B. Swoyer of Charleston, Thomas A. Stamey of Baltimore, John B. Hazard of Cleveland, George A. Wolf, Jr., of Burlington, Vermont, and Kenneth G. MacDonald of Charleston, a member of the Program Committee.

(4) The program at the second general scientific session was presented by members of the faculty at the WVU School of Medicine. Left to right, Drs. Edmund B. Flink, Bernard Zimmermann, William A. Thornhill, Jr., of Charleston, a member of the Program Committee, and Herbert E. Warden.

(5) Dr. Edward M. Litin of Rochester, Minnesota, right, talks with Drs. G. Thomas Evans, left, and Clark K. Sleeth, Assistant to the Dean at the WVU School of Medicine.

### Camera Highlights

(1) Dr. E. Vincent Askey, AMA President, is interviewed by Burl Osborne, staff writer for the Associated Press.

(2) Dr. John W. Hash, left, the new president, with Dr. D. E. Greenetch, president elect, at the first session of the House of Delegates.

(3) Dr. and Mrs. Askey greet guests at the reception honoring Association officers on Saturday evening, August 27.

(4) Dr. Clark K. Sleeth, left, Assistant to the Dean at the WVU School of Medicine, talks with new faculty members, Dr. William G. Klingberg (center) and Dr. Nicholas W. Fugo.

(5) Exhibit on "Surgery for Hearing" was prepared for display at the annual meeting by Dr. William C. Morgan, Jr., of Charleston.

(6) The president of the Pennsylvania Medical Society, Dr. Allen W. Cowley of Harrisburg, was one of the honor guests introduced at the final session of the House of Delegates. He is escorted to the podium by Dr. J. P. McMullen of Wellsburg, a past president of the State Medical Association.

(7) Delegates confer during first session of the House. Left to right, Drs. Richard W. Corbitt of Parkersburg, Carl B. Hall of Charleston, Seigle W. Parks of Fairmont, Buford W. McNeer of Hinton and Everett H. Starcher of Logan.

(8) Dr. George F. Evans of Clarksburg, left, with two out-of-state guests at the meeting, Dr. and Mrs. Murray L. Maurer of Roslyn, New York.

(9) Dr. Thomas L. Harris of Parkersburg, left, a past president of the State Medical Association, with Dr. William R. Laird of Montgomery (center) and Dr. Charles L. Goodhand of Parkersburg.

(10) Dr. Athey R. Lutz of Parkersburg, left, with Dr. Fred R. Whittlesey of Morgantown.

(11) Dr. E. Vincent Askey, AMA president, with Drs. Frank J. Holroyd of Princeton and Charles A. Hoffman of Huntington, AMA delegates from West Virginia, and C. B. Pride of Morgantown, a member of the Medical Licensing Board.

## Hupp E. Otto of Wheeling Heads W. Va. TB and Health Assn.

Hupp E. Otto of Wheeling was elected president of the West Virginia Tuberculosis and Health Association during the annual meeting held in Morgantown, September 7-8. He succeeds Dr. Ralph H. Nestmann of Charleston.

Other new officers were elected as follows:

Vice President, Dr. J. J. Lawless, Morgantown; secretary, Mrs. Robert S. Meighen, Weirton (reelected); and treasurer, Robert C. Hawkins, Charleston (reelected).

New officers of the West Virginia Trudeau Society, medical section of the Association, were elected as follows:

President, Dr. Karl J. Myers, Philippi; vice president, Dr. Alberto Adam, Charleston; and secretary-treasurer, Dr. Morris H. O'Dell, Charleston (reelected).

During a business session of the Association, the Board of Directors went on record unanimously as endorsing the action of the Council of the West Virginia State Medical Association and the West Virginia Chapter of the American Academy of General Practice with reference to the adoption of resolutions deploring the dismissal of Dr. A. L. Starkey as superintendent of Hopemont Sanitarium.

### Relocations

Dr. Carl J. Greever of Whitesville has moved to Williamson, where he will continue in general practice as a member of the staff of the Williamson Memorial Hospital.

* * * *

Dr. D. Brown Barber of Charleston, who received his M. D. degree from the Medical College of Virginia in 1957, has completed a two-year residency in general practice at McLaren General Hospital in Flint, Michigan, and located in Charleston. He has offices at 906-A Walnut Road, South Hills, where he will engage in general practice. He will also serve as part-time physician for the West Virginia Vocational Rehabilitation Center in Institute.

* * * *

Dr. Charles S. Flynn of Bluefield has completed a three-year residency in obstetrics and gynecology at Duke Hospital in Durham, North Carolina, and has returned to his home city. Bluefield Sanitarium Clinic has announced his reassociation with Drs. E. W. McCauley, John H. Sproles and Charles G. Thedieck, Jr., in the Department of Obstetrics and Gynecology.

### Blue Shield Enrollment Spurts

The National Association of Blue Shield Plans announced recently that the 74 Plans in North America reported a net gain of 151,394 new members during the second quarter of 1960, bringing total enrollment to 45,798,636 as of June 30.

## Dr. A. C. Woofter Named President Of W. Va. Heart Association

Dr. Andrew C. Woofter of Parkersburg was elected president of the West Virginia Heart Association at the Annual Meeting in that city on September 16. Other officers were elected as follows:

President elect, Dr. Morris H. O'Dell, Charleston; vice president, Dr. Seigle W. Parks, Fairmont; secretary, Mrs. Laurence Meharg, Wheeling; and treasurer, Mr. R. E. Plott, Charleston (reelected).

The following physicians were elected members of the Board of Directors:

Drs. D. Sheffer Clark and John J. Brandabur, Huntington; Lyle D. Vincent, Parkersburg; A. C. Thompson, Elkins; and Otis J. King, Bluefield.

### New Association Members

Dr. Robert McCune, Jr., Medical Examiner's Office, Grafton (Taylor). Doctor McCune, a native of Belfast, Ireland, received his M. D. degree from the University of Illinois College of Medicine in 1934. He interned at St. Vincent's Hospital in Portland, Oregon, and served a residency at St. Joseph's Hospital in Aurora, Illinois, 1937-38. He served with the Medical Corps of the United States Air Force, 1942-45, and formerly served as a medical officer with the United States Indian Service, USPHS, in Arizona, New Mexico and Washington, D. C.

* * * *

Dr. Glenn F. Van Winkle, E. I. duPont deNemours and Company, Belle (Kanawha). Doctor Van Winkle was born in Charleston and received his M. D. degree from the Medical College of Virginia in 1954. He interned at Charleston General Hospital, 1954-55, and was formerly located at Cross Lanes, Kanawha County. His specialty is industrial medicine.

Dr. E. Vincent Askey, center, president of the American Medical Association, is shown with Dr. John W. Hash of Charleston, left, president of the State Medical Association, and Dr. J. C. Huffman of Buckhannon, immediate past president.

## Fifth Annual Postgraduate Institute At Martinsburg, Oct. 21-23

The Fifth Annual Potomac-Shenandoah Valley Postgraduate Institute, sponsored jointly by the Eastern Panhandle Medical Society and the West Virginia Chapter of the American Academy of General Practice, will be held in Martinsburg, October 21-23.

Twenty-six prominent physicians and surgeons will appear as guest speakers during the three-day meeting.

Harlow Shapley, Ph. D.

Ernest K. Lindley

Scientific and industrial exhibits will be housed in the Shenandoah Hotel and scientific sessions will be held in the Apollo Theater.

Dr. Halvard Wanger of Shepherdstown, the general chairman, has announced that the program will also feature addresses by Ernest K. Lindley, director of the Washington Bureau of *Newsweek*; Dr. Harlow Shapley, prominent astronomer; and Dr. Bell I. Wiley, noted Civil War author and historian.

Members of the American Academy of General Practice will be granted 17 hours Category One Credit for attendance at the three-day meeting.

### Friday Morning Session

The first scientific session will be held on Friday morning, October 21, at which time the following program on surgery will be presented:

"Varicose Veins and Stasis Problems."—Frederich B. Wagner, Jr., M. D., Clinical Professor of Surgery, The Jefferson Medical College, Philadelphia.

"Management of Intestinal Obstruction."—Manuel E. Lichtenstein, M. D., Associate Professor of Surgery, Northwestern University School of Medicine, Chicago.

"Diverticulosis, Diverticulitis and Cancer."—Robert W. Buxton, M. D., Professor and Head of the Department of Surgery, University of Maryland School of Medicine, Baltimore.

"Cardiac Arrest."—Brian Blades, M. D., Professor and Head of the Department of Surgery, George Washington University School of Medicine, Washington, D. C.

### Friday Afternoon

Following a recess for luncheon and visiting exhibits, the following program on medicine will be presented:

"Cerebral Vascular Disease."—Bernard J. Alpers, M. D., Professor and Head of the Department of Neurology, The Jefferson Medical College, Philadelphia.

"Liver Disease."—Charles M. Caravati, M. D., Clinical Professor of Medicine, Medical College of Virginia, Richmond.

"Intersex Problem."—T. S. Danowski, M. D., Professor of Medicine, University of Pittsburgh School of Medicine, Pittsburgh.

"Arterial Obstruction."—William Dock, M. D., Professor of Medicine, State University of New York, New York City.

"Doctor and Patient."—Lawrence A. Kohn, M. D., Clinical Professor of Medicine, University of Rochester School of Medicine, Rochester, New York.

### Address by Ernest K. Lindley

Ernest K. Lindley will be the speaker at the dinner on Friday evening. His subject will be "Washington Tides."

Physicians and their wives are invited to attend a performance of "Golden Fleecing," which will be presented by the Barter Theatre group on Friday evening following the dinner meeting.

### Saturday Morning Session

The morning and afternoon sessions on Saturday will be devoted to medicine. The speakers and their subjects for the morning session are as follows:

"Cardiotonic Glycosides."—John C. Krantz, Ph. D., Professor and Head of the Department of Pharmacology, University of Maryland School of Medicine, Baltimore.

"Peripheral Vascular Disease."—Louis A. M. Krause, M. D., Clinical Professor of Medicine, University of Maryland School of Medicine, Baltimore.

"Diabetic Acidosis."—Perry S. MacNeal, M. D., Associate Clinical Professor of Medicine, University of Pennsylvania School of Medicine, Philadelphia.

"Routine Urinalysis."—George E. Schreiner, M.D., Associate Professor of Medicine, Georgetown University School of Medicine, Washington, D. C.

### Afternoon Session

There will be a round table discussion at the luncheon at noon on Saturday. The program for that afternoon will be a continuation of the morning program on medicine. The speakers and their subjects are as follows:

"Cystic Fibrosis."—John A. Prior, M. D., Professor of Medicine, Ohio State University School of Medicine, Columbus.

"Blood Groups."—Milton S. Sacks, M. D., Clinical Professor of Medicine, University of Maryland School of Medicine, Baltimore.

"The Chemoprophylaxis of Infection."—Louis Weinstein, M. D., Professor of Medicine, Tufts University School of Medicine, Boston.

"Staphylococcal Infections."—Robert L. Wise, M. D., Professor and Head of the Department of Medicine, The Jefferson Medical College, Philadelphia.

"Steroid Therapy."—Walter Bundy, M. D., Associate Professor of Pediatrics, Medical College of Virginia, Richmond.

### Dr. Harlow Shapley Banquet Speaker

Dr. Harlow Shapley, who is regarded by many as the "world's leading astronomer," will be the guest speaker at the banquet on Saturday evening. His subject will be "Extra-Terrestial Biology."

### Sunday Morning Session

All papers that will be presented on Sunday morning will concern pediatrics. The program follows:

"Infant Feeding."—McLemore Birdsong, M. D., Professor of Pediatrics, University of Virginia School of Medicine, Charlottesville.

"The School Problem."—Earl H. Baxter, M. D., Professor and Chairman of the Department of Pediatrics, Ohio State University School of Medicine, Columbus.

"Mental Retardation."—Weston M. Kelsey, M. D., Professor and Head of the Department of Pediatrics, Bowman Gray School of Medicine, Winston-Salem, North Carolina.

"Hemorrhagic Disorders." — Leondro Tocantins, M. D., Professor of Clinical and Experimental Medicine, The Jefferson Medical College, Philadelphia.

### 'Johnny Reb and Billy Yank'

Dr. Bell I. Wiley, Civil War author and historian, will be the guest speaker at the luncheon held at noon on Sunday. His subject will be "Johnny Reb and Billy Yank."

### Afternoon Session

The following program on obstetrics and gynecology will be presented on Sunday afternoon:

"Teenage Menstrual Problems."—M. Edward Davis, M. D., Professor and Head of the Department of Obstetrics and Gynecology, University of Chicago School of Medicine, Chicago.

"Pregnancy Anemias."—John L. McKelvey, M. D., Professor and Head of the Department of Obstetrics and Gynecology, University of Minnesota School of Medicine, Minneapolis.

"Toxemia of Pregnancy."—James G. Sites, M. D., Assistant Professor of Obstetrics and Gynecology, George Washington University School of Medicine, Washington, D. C.

"Endometriosis."—Richard W. Te Linde, M. D., Professor and Head of the Department of Gynecology, Johns Hopkins School of Medicine, Baltimore.

The registration fee is $20 for the entire three-day course and $10 for a single day. Further information concerning the Institute may be obtained by writing to Halvard Wanger, M. D., General Chairman, Box 175, Shepherdstown, West Virginia.

## Medical Meetings, 1960

The following is a partial list of national, state and district medical meetings scheduled for 1960.

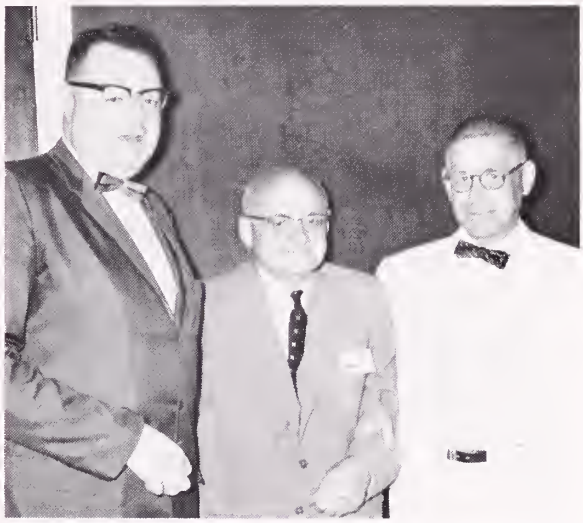
Oct. 3—Medical Licensing Board, Charleston.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 8-9—Maryland GP Acad., Baltimore.
Oct. 9-14—Am. Acad. Oph. and Otol., Chicago.
Oct. 10-14—ACS, San Francisco.
Oct. 12-15—Mid-Atlantic Section AUA, Atlantic City.
Oct. 17-20—Am. Acad. Pediatrics, Chicago.
Oct. 21-22—S. E. Allergy Assn., Atlanta.
Oct. 21-23—PG Institute, Martinsburg.
Oct. 21-25—Am. Heart Assn., St. Louis.
Oct. 22-23—Pittsburgh Allergy Society, Pittsburgh.
Oct. 30-31—Southern Chap., ACCP, St. Louis.
Oct. 30-Nov. 1—Assn. American Medical Colleges, Hollywood, Beach, Fla.
Oct. 31-Nov. 3—Southern Medical, St. Louis.
Nov. 29-Dec. 2—AMA Clinical Meeting, Washington D. C.
Dec. 6-8—Southern Surgical Assn., Boca Raton, Fla.

## Scholarship Established in Honor Of Dr. Thomas L. Harris

A medical scholarship has been established at West Virginia University in honor of Dr. Thomas L. Harris, surgeon of Parkersburg, who was a member of the WVU Board of Governors, 1945-1960, during which time he served two terms as president.

University President Elvis J. Stahr, Jr., said that the scholarship which is worth $400 annually will be supported by income from a gift of $7,500 by the family of the late Anna M. Broida of Parkersburg.

The new scholarship became effective at the beginning of the current academic year, and the first recipient was to be selected prior to the beginning of the first semester. President Stahr said that preference will be given to students planning careers in surgery.



Dr. Merle S. Scherr of Charleston, left, who served as moderator at a scientific session sponsored by the West Virginia State Society of Allergy during the annual meeting, is shown with the guest speakers, Dr. M. Murray Peshkin of New York City, center, and Dr. Ethan Allan Brown of Boston.

## Dr. Carl B. Jarrell of Charleston Wins Skeet Tournament

Dr. Carl B. Jarrell of Charleston won top honors in the skeet shooting tournament held in connection with the 93rd Annual Meeting of the State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

Doctor Jarrell won the Class A championship by shooting a perfect 50 out of 50. Runner-up was Dr. D. Franklin Milam of Morgantown, who shot 47 out of 50. Class B and C honors went to Drs. T. P. Mantz of Charleston and O. M. Harper of Clendenin.

Trophies were awarded to winners of the tournament which was held at The Greenbrier Gun Club on nearby Kate's Mountain.

Doctor Mantz served as chairman of the committee in charge of the tournament and the other members were Drs. J. L. Patterson of Logan and Albert C. Esposito of Huntington.

## Standing and Special Committees Named by Dr. John W. Hash

Standing and special committees have been named by Dr. John W. Hash to serve during his term of office as president of the West Virginia State Medical Association. He was installed and assumed his duties at the final session of the House of Delegates at The Greenbrier on Saturday, August 27. He will serve for the year ending on the last day of the annual meeting in 1961.

Chairmen and members of all committees were notified officially of their appointment by Doctor Hash by letters mailed from the headquarters offices of the State Medical Association.

The complete list of committees follows:

### STANDING COMMITTEES

**Aging:** George R. Callender, Jr., Charleston, Chairman; Thomas H. Blake, St. Albans; N. H. Dyer, Charleston; E. Lyle Gage, Bluefield; D. E. Greeneltch, Wheeling; C. Royall Kessel, Ripley; Thomas S. Knapp and John N. Marquis, Charleston; L. J. Pace, Princeton; James L. Wade, Parkersburg; and Fred R. Whittlesey, Morgantown.

**Cancer:** T. P. Mantz, Charleston, Chairman; Eugene S. Brown, Summersville; John T. Jarrett and J. Dennis Kugel, Charleston; J. I. Markell, Princeton; William D. McClung, Charleston; D. F. Milam, Morgantown; Russell A. Salton, Jr., Williamson; I. Ewen Taylor, Huntington; C. Truman Thompson, Morgantown; J. H. Wolverton, Piedmont; and Chauncey B. Wright, Huntington.

**Conservation of Vision and Hearing:** Ralph W. Ryan, Morgantown, Chairman; Nime K. Joseph, Wheeling; William C. Morgan, Jr., Charleston; Frederick C. Reel, South Charleston; and Edwin M. Shepherd, W. F. Shirkey, and James T. Spencer, Charleston.

**Constitution and By-Laws:** Buford W. McNeer, Hinton, Chairman; Daniel N. Barber, Charleston; Myer Bogarad, Weirton; A. C. Chandler, Charleston; Francis L. Coffey and George M. Lyon, Huntington; Daniel A. Mairs, Charleston; S. Elizabeth McFetridge, Shepherdstown; R. R. Pittman, Marlinton; and Wade H. St. Clair, Bluefield.

**Insurance:** Charles A. Hoffman, Huntington, Chairman; Herbert M. Beddow, Charleston; W. P. Bittinger, Summerlee; Duke A. Dent, Charleston; Upshur Higginbotham, Bluefield; Frank V. Langfitt, Clarksburg; C. A. Logue, Morgantown; D. H. Lough, Clarksburg; Paul L. McCuskey, Parkersburg; Richard N. O'Dell, Charleston; and L. D. Zinn, Clarksburg.

**Legislative:** Frank J. Holroyd, Princeton, Chairman; Don S. Benson, Moundsville; W. Paul Elkin, Charleston; Logan W. Hovis, Parkersburg; W. W. Huffman, Gassaway; John F. Morris, Huntington; James L. Patterson, Logan; Thomas G. Reed, Charleston; Raymond A. Updike, Montgomery; and Harold Van Hoose, Man.

**Maternal Welfare:** A. J. Villani, Welch, Chairman; Harold D. Almond, Buckhannon; John L. Crites, Charleston; Dwight P. Cruikshank, III, Parkersburg; Frederick H. Dobbs, Charleston; E. J. Humphrey, Jr., Huntington; J. Preston Lilly, Charleston; and Gilbert A. Ratcliff and Gates J. Wayburn, Huntington.

**Medical Economics:** James S. Klumpp, Huntington, Chairman; James A. Heckman, Huntington; Carl E. Johnson, Morgantown; Athey R. Lutz, Parkersburg; John E. Lutz, Charleston; J. P. McMullen, Wellsburg; John F. Morris, Huntington; Seigle W. Parks, Fairmont; J. C. Pickett, Morgantown; W. Frederick Richmond, Beckley; Charles M. Scott, Bluefield; L. Dale Simmons, Clarksburg; Ray H. Wharton, Parkersburg; and J. D. H. Wilson, Clarksburg.

**Medical Education and Scholarships:** J. P. McMullen, Wellsburg, Chairman; Harry C. Fleming, Fairmont; Carl B. Hall, Charleston; Thomas L. Harris, Parkersburg; Joe N. Jarrett, Oak Hill; F. L. Johnston, Welch; Russel Kessel, Charleston; Clark K. Sleeth, Morgantown; and William A. Thornhill, Jr., Charleston.

**Medical Emergencies and Civil Defense:** Eugene J. Ryan, Belle, Chairman; A. A. Abplanalp, Joel Allen, J. A. B. Holt and Marion F. Jarrett, Charleston; L. Rush Lambert, Fairmont; Charles T. Lively, Weston; Richard V. Lynch, Jr., Clarksburg; Earl A. McCowen, South Charleston; George Miyakawa, Charleston; Robert J. Reed, Jr., Wheeling; William H. Riheldaffer, Charleston; Richard J. Stevens, Huntington; and James E. Wilson, Jr., Clarksburg.

**Medico-Legal:** L. E. Neal, Clarksburg, Chairman; Richard W. Corbitt, Parkersburg; Richard E. Flood, Weirton; John T. Gocke, Clarksburg; George R. Maxwell, Morgantown; Thomas G. Reed, Charleston; Walter E. Vest, Huntington; and W. V. Wilkerson, Whitesville.

**Mental Health:** William B. Rossman, Charleston, Chairman; John H. Gile, Parkersburg; R. W. Hibbard, Huntington; J. J. Lawless, Morgantown; Archie C. Thompson, Elkins; C. Carl Tully, South Charleston; A. L. Wanner, Wheeling; David M. Wayne, Bluefield; and W. E. Wilkinson, Beckley.

**Necrology:** J .W. Hesen, Jr., Morgantown, Chairman; J. David Brown, Craigsville; O. D. MacCallum, Madison; John J. Mahood, Bluefield; and Stephen Mamick, White Sulphur Springs.

**Program:** Halvard Wanger, Shepherdstown, Chairman; Thomas H. McGavack, Martinsburg; and Hu C. Myers, Philippi.

**Public Service:** Charles L. Goodhand, Parkersburg, Chairman; John T. Chambers, Charleston; William L. Claiborne, Montgomery; Sobisca S. Hall, Clarksburg; Carl E. Johnson, Morgantown; George E. Snider, Bluefield; Everett H. Starcher, Logan; and Lawrence B. Thrush, Clarksburg.

**Resolutions:** Pat A. Tuckwiller, Charleston, Chairman; A. C. Esposito, Huntington; D. A. MacGregor, Wheeling; Curtis G. Power, Martinsburg; Maynard P. Pride, Morgantown; and Howard A. Swart, Charleston.

**Rehabilitation:** J. C. Pickett, Morgantown, Chairman; W. Carroll Boggs, Wheeling; James A. Heckman, Huntington; Henry M. Hills, Jr., Russel Kessel, Milton J. Lilly, Jr., and Ralph H. Nestmann, Charleston; and Walter E. Vest, Huntington.

**Rural Health:** Charles E. Staats, Charleston, Chairman; Andrew E. Amick, Lewisburg; J. C. Arnett,

Rowlesburg; J. M. Brand, Chester; J. M. Cofer, Bergoo; Martha J. Coyner, Harrisville; R. W. Cronlund, Philippi; L. A. Dickerson, Charleston; S. Charles Dotson, Jr., Morgantown; Earl L. Fisher, Gassaway; O. M. Harper, Clendenin; J. E. Martin, Jr., Elkins; and John W. Trenton, Kingwood.

**Syphilis:** Bruce H. Pollock, Huntington, Chairman; David F. Bell, Jr., Bluefield; A. M. Benshoff, Jr., Ronceverte; N. H. Dyer, Charleston; Marcus E. Farrell, Clarksburg; H. C. Hays, Athens; Thomas J. Holbrook, Huntington; W. W. Mills, Kenova; and C. Y. Moser, Kingwood.

**Tuberculosis:** William L. Cooke, Charleston, Chairman; Deane F. Brooke, Beckley; Robert J. Fleming, Morgantown; C. S. Harrison, Clarksburg; Karl J. Myers, Philippi; and Frank M. Peck and M. L. White, Jr., Huntington.

**SPECIAL COMMITTEES**

**American Medical Education Foundation:** C. R. Davisson, Weston, Chairman; George A. Curry, Morgantown; Morris H. O'Dell, Charleston; J. Keith Pickens, Clarksburg; William R. Rice, Dunbar; W. W. Scott, Williamson; Charles E. Watkins, Oak Hill; and E. Andrew Zepp, Martinsburg.

**Medico-Pharmaceutical Relations:** L. Dale Simmons, Clarksburg, Chairman; William S. Herold, Fayetteville; Donald R. Roberts, Elkins; Theresa O. Snaith, Weston; and Gordon L. Todd, Jr., Princeton.

**Nurses Liaison:** Clyde A. Smith, Beckley, Chairman; Andrew E. Amick, Lewisburg; John C. Condry, Charleston; Thomas G. Folsom, Huntington; George W. Rose, Clarksburg; E. J. Van Liere, Morgantown; and John W. Whitlock, Beckley.

**School Health:** W. W. Currence, South Charleston, Chairman; Hunter Boggs, Charleston; Grover C. Hedrick, Jr., and Charles W. Merritt, Beckley; Merle S. Scherr, Charleston; Herman Seltz, Elkins; Charles N. Slater, Clarksburg; Joseph A. Smith, Dunbar; Wilson P. Smith, Huntington; and Frederick D. White, Bluefield.

**WVU Liaison:** George F. Evans, Clarksburg, Chairman; Dante Castrodale, Welch; R. U. Drinkard, Wheeling; Carl B. Hall, Charleston; Charles L. Leonard, Elkins; Kenneth G. MacDonald, Newman H. Newhouse and R. R. Summers, Charleston; and Ward Wylie, Mullens.

## Dr. Robt. A. Kimbrough Assumes Duties As Medical Director of ACOG

Dr. Robert A. Kimbrough, Jr., of Philadelphia, has assumed his duties in the newly created post of medical director of the American College of Obstetricians and Gynecologists. His offices will be at the headquarters of the ACOG at 79 West Monroe Street, Chicago.

It will be the responsibility of the medical director to lead and coordinate the activities of the College and its committees.

Doctor Kimbrough is consultant in gynecology and obstetrics to the Surgeon General of the Army. For several years he was vice president of the American Board of Obstetrics and Gynecology.

## Dr. J. T. Mallamo Wins Permanent Possession of Golf Trophy

Dr. Joseph T. Mallamo of Fairmont shot a three under par 67 to win the medical golf tournament held in connection with the 93rd Annual Meeting at The Greenbrier in White Sulphur Springs, August 25-27.

It was Doctor Mallamo's fifth consecutive victory in the annual medical golf tournament and he retired the beautiful championship trophy offered by the Hospital and Physicians Supply Company of Charleston.

Joseph T. Mallamo, M. D.

His closest rivals for low gross honors were Drs. Eugene J. Morhous of White Sulphur Springs and Jack Leckie of Huntington, both of whom shot 75's. Other low scorers were Drs. Frank W. Mallamo, 77, Joseph A. Smith of Dunbar and W. C. Morgan, Jr., of Charleston, 78, and E. B. Wray of Beckley and George A. Curry of Morgantown, 79.

Drs. Tracy N. Spencer of South Charleston and Joseph G. Doboy of Fairmont tied for low net honors and among the other winners in this category were Drs. J. D. H. Wilson of Clarksburg, R. H. Fowlkes of Bluefield, Sobisca S. Hall of Clarksburg, Paul C. Soulsby of St. Albans, and George R. Callender, Jr., and Robert A. Crawford, Jr., both of Charleston.

C. W. Mathias of Pittsburgh, representative of Baker Laboratories, won low gross honors in the tournament for guest physicians and exhibitors.

Winners in the various categories of the tournament received useful golfing equipment purchased from funds realized from a $5 registration fee.

Doctor Mallamo was chairman of this year's golf committee and the other members were Drs. Robert S. Wilson of Clarksburg and George A. Curry of Morgantown.

## Southern Medical Assn. Meeting In St. Louis, Oct. 31-Nov. 3

Plans are being completed for the 54th annual meeting of the Southern Medical Association which will be held in St. Louis, Missouri, October 31-November 3.

Dr. Grayson Carroll, general chairman, has announced that the program during the four-day meeting will feature scientific sessions arranged by 20 sections of the Association, and symposiums on "Cerebrovascular Disease" and "The Business Side of Medicine."

Scientific sessions will be held in Kiel Auditorium and more than 200 scientific and industrial exhibits will also be housed there.

Further information concerning the program may be obtained by writing to Mr. Robert F. Butts, Executive Secretary-Treasurer, Southern Medical Association, 2601 Highland Avenue, Birmingham, Alabama.

## Mrs. Clark K. Sleeth of Morgantown New Auxiliary President

Mrs. Clark K. Sleeth of Morgantown was installed as president of the Woman's Auxiliary to the West Virginia State Medical Association at the 36th annual meeting of the organization at The Greenbrier in White Sulphur Springs, August 25-27. She succeeds Mrs. Robert R. Pittman of Marlinton, who has served during the past year.

The convention was held conjointly with the 93rd annual meeting of the West Virginia State Medical Association.

The Auxiliary registration for the three-day meeting was 242, which exceeded the previous high of 223 set in 1958.

Mrs. Sleeth and the other newly elected officers were installed at the second general session on Friday morning, August 26, by Mrs. William Mackersie of Detroit, Michigan, president of the Woman's Auxiliary to the American Medical Association. Mrs. Sleeth delivered her inaugural address at this session.

Mrs. Clark K. Sleeth

Another honor guest at the meeting was Mrs. John M. Chenault of Decatur, Alabama, president of the Woman's Auxiliary to the Southern Medical Association. She appeared as a guest speaker on Friday morning, August 26.

### Mrs. Dyer Named President Elect

Mrs. Vernon L. Dyer of Petersburg was named president elect and will be installed as president during the 1961 meeting at The Greenbrier next August. Other new officers for the coming year are as follows:

First vice president, Mrs. C. Stafford Clay, Huntington; second vice president, Mrs. George A. Curry, Morgantown; third vice president, Mrs. Pat A. Tuckwiller, Charleston; fourth vice president, Mrs. Earl S. Phillips, Wheeling; treasurer, Mrs. Andrew J. Weaver, Clarksburg; recording secretary, Mrs. Rupert W. Powell, Fairmont; corresponding secretary, Mrs. Clement A. Smith, Morgantown; and parliamentarian, Mrs. C. R. Davisson, Weston.

Mrs. Sleeth has named the following chairmen of committees to serve during her term of office:

### Standing Committees

Archives, Mrs. William T. Lawson, Fairmont; Finance, Mrs. Harry E. Beard, Huntington; Legislation, Mrs. L. Dale Simmons, Clarksburg; Community Service, Mrs. Justus C. Pickett, Morgantown; Membership, Mrs. Vernon L. Dyer, Petersburg; Press and Publicity, Mrs. John C. Condry, Charleston; Program, Mrs. A. C. Chandler, Charleston; Editor, State News Bulletin, Mrs. E. J. Van Liere, Morgantown; Circulation Manager, Mrs. H. A. Shaffer, Morgantown; By-Laws and Handbook, Mrs. William A. Thornhill, Jr., Charleston; Southern Medical Councillor, Mrs. J. C. Huffman, Buckhannon; National Bulletin, Mrs. Joseph A. Smith, Dunbar; Members-at-Large, Mrs. Hu C. Myers, Philippi; and American Medical Education Foundation, Mrs. Grover C. Hedrick, Beckley.

### Special Committees

Convention, Mrs. Robert J. Nottingham, Morgantown, and Assistant, Mrs. Robert J. Fleming, Morgantown; Necrology, Mrs. Paul P. Warden, Grafton; Paramedical Careers, Mrs. A. J. Villani, Welch; Safety, Mrs. Buford W. McNeer, Hinton; Mental Health, Mrs. George F. Evans, Clarksburg; Nutrition, Mrs. William A. Ehrgott, Fairmont; Rural Health, Mrs. Lynwood D. Zinn, Clarksburg; Civil Defense, Mrs. George F. Pugh, Martinsburg; and Liaison to Woman's Auxiliary, Student American Medical Association, Mrs. George A. Curry, Morgantown.

### Executive Board

Two past presidents of the Auxiliary, Mrs. G. Thomas Evans of Fairmont and Mrs. Robert R. Pittman of Marlinton, have been appointed by Mrs. Sleeth to serve as members of the Executive Board.

### Advisory Board

Dr. John W. Hash of Charleston, president of the West Virginia State Medical Association, has named the following Advisory Board to the Woman's Auxiliary:

Dr. J. C. Huffman, Buckhannon, chairman; and Drs. Buford W. McNeer, Hinton; George F. Evans, Clarksburg; John C. Condry, Charleston; and Clark K. Sleeth, Morgantown.

### New President Native of Morgantown

Mrs. Sleeth is a native of Morgantown and was educated in the public schools of that community. She was graduated from West Virginia University, receiving a Bachelor of Arts degree in romance languages.

She was active in various campus organizations and was a member of Phi Beta Kappa.

She was married in 1936 to Dr. Clark K. Sleeth, Assistant to the Dean and Associate Professor of Medicine at the West Virginia University School of Medicine. They have three daughters, Ann Alice, a senior at the University, Mary Virginia, a senior at Morgantown High School, and Jane Adella, a sixth grade student at Second Ward School.

Mrs. Sleeth is a charter member of the Woman's Auxiliary to the Monongalia County Medical Society and has been active for many years in the work of the State Auxiliary. Prior to being named president elect in August, 1959, she had served as legislation chairman, recording secretary, editor of the *News Bulletin*, chairman of the program and necrology committees, and second vice president.

In addition to medical auxiliary work, Mrs. Sleeth has served two terms as president of the Auxiliary to the Monongalia General Hospital. She also organized and sponsored a junior volunteer group of Candy Stripers for the hospital.

She serves as superintendent of the Youth Division of the Wesley Methodist Church and is on the advisory board of the local Order of Rainbow Girls.

Mrs. Sleeth is a member of the Order of Eastern Star, Woman's Music Club, D.A.R., Campus Club of WVU, P.T.A., and Delta Delta Delta, national social sorority.

**Inaugural Address by Mrs. Sleeth**

In her inaugural address, Mrs. Sleeth said that in selecting as the state theme for the year, "Promoting an Awareness of the Auxiliary," it was her idea to "make all of us truly aware of the part the Auxiliary can and must play in the realm of organized medicine."

She said that wives of physicians must be active in community affairs so that "the physician's viewpoint is represented in all health agencies and committees. Obviously, this means that you and I must be the medical association's ears and eyes as our husbands do not have time to attend all the meetings called in matters of health."

Mrs. Sleeth urged Auxiliary members to accept committee assignments in community and state agencies. "The doctor and the doctor's wife are natural leaders in the community," she said, "and it is of the utmost importance to have well-informed members of all community agencies."

In the field of medical education, Mrs. Sleeth said the Auxiliary can play an important role in encouraging outstanding young men and women to enter the field of medicine.

"Each of us," she said, "can help by providing promising high school students with information outlining the advantages of being a physician—the physician's role as outstanding citizen, healer and counselor."

**Newly elected officers of the Woman's Auxiliary to the West Virginia State Medical Association are shown together following their election at the annual meeting at The Greenbrier. Seated, left to right, Mrs. Pat A. Tuckwiller, Charleston, third vice president; Mrs. Clark K. Sleeth, Morgantown, president; Mrs. Rupert W. Powell, Fairmont, recording secretary; Mrs. Andrew J. Weaver, Clarksburg, treasurer; and Mrs. Claude R. Davisson, Weston, parliamentarian. Standing, left to right, Mrs. George A. Curry, Morgantown, second vice president; Mrs. Earl S. Phillips, Wheeling, fourth vice president; and Mrs. Vernon L. Dyer, Petersburg, president elect.**

Mrs. Sleeth said it would be impossible to review in detail the many worthwhile activities undertaken and accomplished each year by local and state auxiliaries.

"Each activity," she said, "plays its part in the program we have set up for ourselves and many times they overlap. Perhaps that is a test for a good program, to have its many facets interlocking and woven into a pattern concerning health and the medical profession."

In closing, Mrs. Sleeth said that "when we realize that membership in the Auxiliary does not mean having another social club to attend, but means aid and service freely and gladly given to our husbands and their colleagues, then we can truly say we have promoted an 'Awareness of the Auxiliary.' "

### WVU Dean of Nursing Guest Speaker

Dr. Dorothy Mae Major, Dean of the West Virginia University School of Nursing, appeared as a speaker at the second general session on Friday morning, August 26.

She outlined the proposed nursing program at the WVU Medical Center and said that "it is a forward looking one as compared with many other schools in the nation." She said that the first-year class will be comprised of 29 students, all residents of West Virginia.

"As a school in the University," Doctor Major said, "it will attract students interested in nursing education. It provides a college education with a major in nursing, allowing the nurse to be a University prepared person.

"It will assist in meeting the many nursing needs of the state by providing top level persons to hospitals and health agencies. It will provide the opportunity to create a reserve of nurses who will be able to go into the teaching, administrative and research field."

Doctor Major added that graduates will have "an understanding in many fields, as the nursing students will receive a minor in social sciences. They will thus be better able to communicate with patient's families and other community health agencies."

Dr. Dorothy Mae Major, Dean of the WVU School of Nursing, is welcomed to The Greenbrier by Mrs. A. C. Chandler of Charleston. Doctor Major appeared as a guest speaker before the Woman's Auxiliary on Friday, August 26.

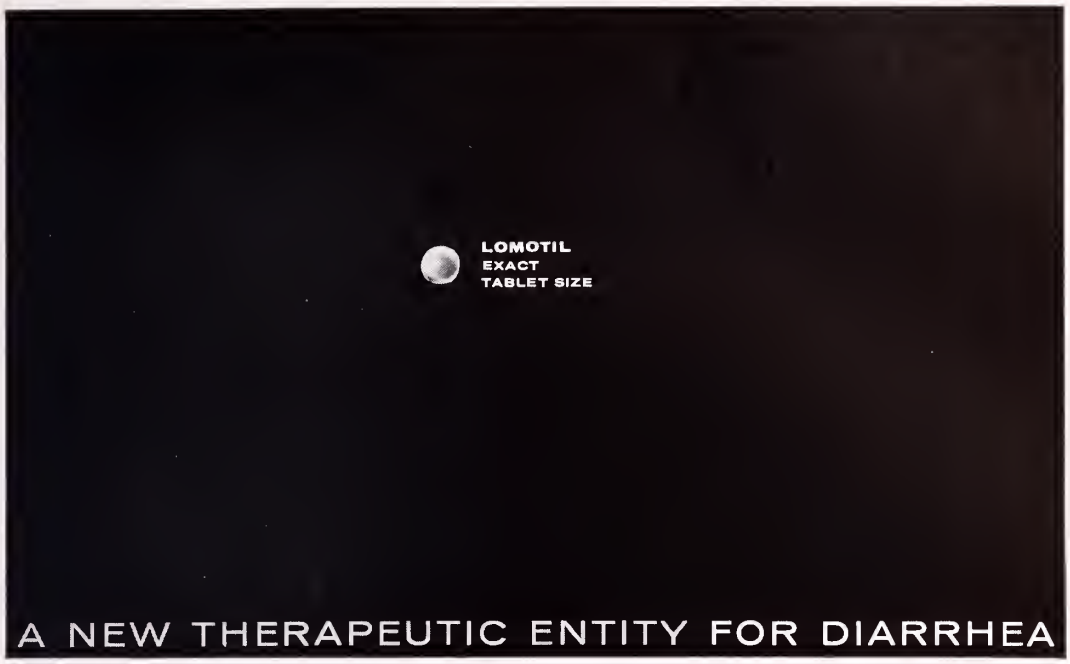
### Auxiliary Entertainment Program

A luncheon and style show was sponsored by the Auxiliary in the Mural Dining Room on Thursday, August 25, following adjournment of the first general session. A capacity crowd composed of members and guests witnessed a preview of the latest fall fashions shown by Alanson's of The Greenbrier and Delray Beach, Florida. Several members of the Greenbrier Valley Auxiliary participated as models in the fashion show.

The featured evening entertainment was a dance in the Ballroom on Friday, August 26. A special program was presented by dancing instructors at the hotel.

In the photo at the left, Mrs. Robert R. Pittman of Marlinton, right, is shown at the Woman's Auxiliary registration desk with Mrs. Eugene J. Morhous, left, and Mrs. Harvey A. Martin, both of White Sulphur Springs. Mrs. Morhous was chairman of the convention committee, assisted by Mrs. Martin.

In the other photo, Mrs. Pittman receives a sterling silver bowl from Mrs. Lee B. Todd of Quinwood, president of the Greenbrier Valley Auxiliary. Mrs. Pittman's local auxiliary presented the bowl to her in appreciation of her services during the past year as president of the State Auxiliary.

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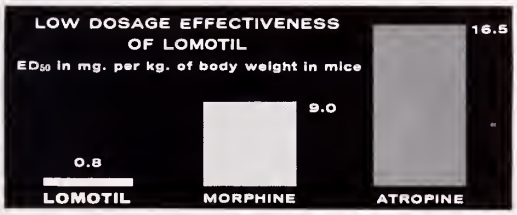


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# WVU Medical Center
# —News—

• Compiled from materiol furnished by John B. Horley, M. D., Assistant Professor of Medicine and Public Information Officer ot the WVU Medical Center in Morgontown, W. Vo.

Dr. Harold I. Amory, chief of the radiological service at Beckley Memorial Hospital since 1956, has accepted appointment as Professor and Chairman of the Department of Radiology at the West Virginia University School of Medicine. The appointment was announced by University President Elvis J. Stahr, Jr.

Harold I. Amory, M. D.

A native of Battery Park, Virginia, Doctor Amory was graduated from Randolph Macon College in 1927 and received his M. D. degree from the Medical College of Virginia in 1931. He interned at St. Vincent's Hospital in Norfolk, Virginia, 1931-32, and served residencies in radiology at several Army hospitals.

Doctor Amory entered the Medical Corps of the United States Army following his medical training and he continued as a member of the regular Army until his retirement in 1955.

He served as chief of radiological services at Walter Reed Army Hospital from 1946 until 1953, then assumed similar responsibilities at Letterman Army Hospital in San Francisco. While at Walter Reed, he was professor of clinical radiology at the Georgetown University Medical School, represented the Army on the National Research Council, and served as chief of the radiological consultants division, Office of the Surgeon General.

Doctor Amory is certified by the American Board of Radiology and is a Fellow of the American College of Radiology. He served a term as vice president of the Radiological Society of North America in 1953.

He is a member of the Raleigh County Medical Society, West Virginia State Medical Association and the American Medical Association.

### Staff Appointments Announced

Dr. C. Gordon Hewes of San Bernadino, California, has accepted appointment as associate professor of gross and neurological anatomy at the West Virginia University School of Medicine.

Doctor Hewes, formerly a member of the faculty at the College of Medical Evangelists in San Bernadino, is a graduate of the Washington Missionary School and received his M. S. and Ph. D. degrees from the University of Maryland. He is active in medical research and has written numerous articles which have appeared in professional journals.

Also announced last month were the appointments of two resident surgeons to the staff of the Teaching Hospital. They are Dr. Emil L. Mantini of Morgantown and Dr. Thomas J. Tarnay of New York City.

Doctor Mantini is a native of Morgantown and a graduate of the University. He received his M. D. degree from the Washington University School of Medicine.

### Five Additional Students Accepted

A list of students accepted for admission this fall to the first-year class at the WVU School of Medicine was published in a previous issue of *The Journal.* Dr. Edward J. Van Liere, Dean, announced recently that the following additional students were accepted for admission to the School of Medicine:

James D. Anderson, Belva; E. Lyle Gage, Jr., Bluefield; Paul T. Gregg, Morgantown; William A. Morrison, Terra Alta; and John S. Palkot, Morgantown.

Dr. Edmund B. Flink, professor and chairman of the Department of Medicine, is shown examining a patient at the WVU Teaching Hospital with two third-year medical students, Frederick M. Cooley of Nitro, left, and Jesse S. Griffith of Charleston. The 16 members of the third-year class began their clinical training early last month and will be the first class of medical students to receive M. D. degrees from the WVU School of Medicine.

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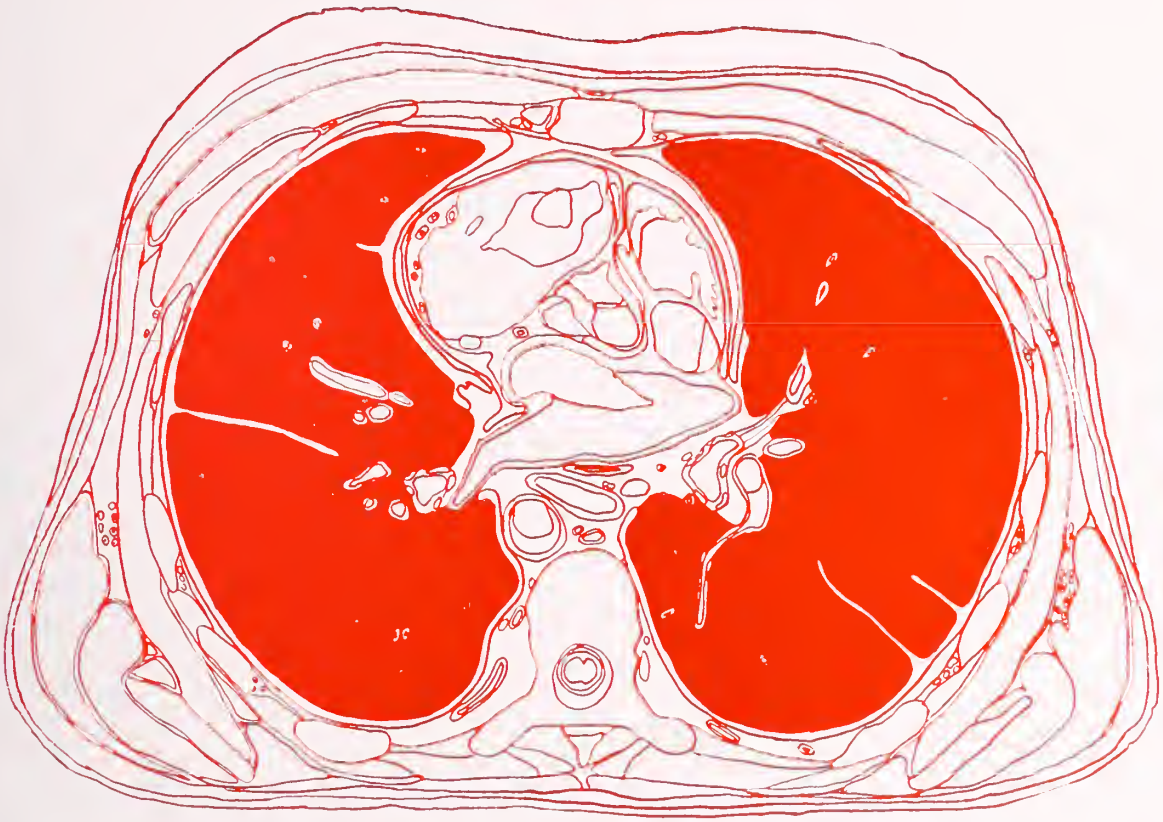

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# The Month in Washington

• From the Washington Office of the American Medical Association.

THE federal government is offering states liberal matching funds to provide health care for needy and near-needy persons 65 years of age and older. The program, which Congress approved in the bob-tailed post-convention session, is supported by the American Medical Association and allied health groups.

Congressional approval of the federal-state program marked a victory for the medical profession and a defeat for Democratic Presidential Nominee John F. Kennedy, the AFL-CIO and other advocates of the Social Security approach to the problem.

In a key vote on the issue, the Senate rejected by a 51-44 vote a Kennedy proposal that would have provided hospitalization and medical care for the aged under the Social Security system. The Kennedy plan would have required an increase in payroll taxes.

Republicans and Southern Democrats joined in the Senate to defeat the Social Security approach which was opposed vigorously by the medical profession.

### Modified Health Care Plan Passed

After voting down the Kennedy plan and a separate proposal of the Eisenhower Administration, the Senate passed a modified version of a House-approved program. The modifications, sponsored by Sen. Robert S. Kerr (D., Okla.) and others, provided for increases in the percentage of federal matching funds and for administrative changes designed to facilitate state participation.

Under the legislation as signed into law by President Eisenhower, substantial increases are authorized in federal grants to states to help with health care expenses of the 2.4 million persons on old age assistance rolls, and federal matching funds are offered the states to finance a new program of health care for an estimated 10 million aged persons who are not on relief but whose incomes may be inadequate to take care of all their health costs.

Start of the program was authorized for Oct. 1 for those states where new state legislation is not required.

### States to Administer Program

Administration of the program rests entirely with the states, subject to Federal approval in broad terms. It is up to each individual state whether it participates. Eligibility standards for beneficiaries and what health care services are provided are matters for the states to decide.

If a state so chooses, it can take care of all the health needs of an eligible beneficiary. The law authorizes in-patient hospital services; skilled nursing home services; physicians' services; out-patient or clinic services; home care services; private duty nursing services; physical therapy and related services; dental services; laboratory and x-ray services; prescribed drugs, eyeglasses, dentures and prosthetic devices; diagnostic screening and preventive services, and any other medical care or remedial care recognized under state law.

For medical expenses of persons on old age assistance rolls, the federal government will contribute 50 to 80 percent—with states with low per capita income getting the larger percentages of federal aid—of an amount equal to $12 multiplied by the number of old age assistance recipients in a particular state.

The matching formula will be the same for financing the health care of the near-needy, but there is no $12 limitation figure.

Health, Education and Welfare officials estimated first-year costs of the program at $262 million, $202 million federal and 60 million state. Annual costs are estimated to rise by the end of the fifth year to $340 million federal and $180 million state; however, these estimates admittedly are no more than educated "guesstimates" because so much depends upon state action.

### W. Va. To Receive $642,000 Under Program

It was estimated that maximum participation and a state contribution of $28,000 would bring West Virginia $642,000 in federal matching funds in the first year of the program.

The medical-care-for-the-aged legislation was included in an omnibus measure titled Social Security Amendments of 1960. It also eliminated the age 50 requirement for eligibility for disability insurance benefits.

### Senate Kills Social Security for Physicians

The Senate knocked out of the House bill a provision that would have brought physicians under Social Security coverage.

The Senate failed to act upon House-approved legislation that would have given physicians and other self-employed persons a tax break on income put into private pension plans.

# Annual Reports*

### Executive Secretary

The loss of members of the West Virginia State Medical Association during the past year because of relocation outside the state was not as heavy as during the Association year 1958-59, and there was a noticeable decline in the number of deaths reported during the year.

Nearly twenty more physicians were elected to membership than during the preceding year, while the small number of physicians in active service with our Armed Forces remained about the same.

Membership in the West Virginia State Medical Association totaled 1458 as of August 15, 1960. Of this number, 144 were honorary life members. During the year, 67 new physicians were elected to membership; however, there was a loss of thirty members by death, 25 by relocation outside of West Virginia, and ten on account of non-payment of dues, leaving a net gain of two members for the year.

There are four members in active service with our Armed Forces, one less than in 1959.

Members who paid state dues totaled 1310. This is a gain of three over 1959. Of the 1310 dues-paying members, 1286, or 98 per cent, also paid AMA dues. Dues are waived for honorary life members and for those serving with our Armed Forces.

### Journal Activities

Advertising in *The West Virginia Medical Journal*, official publication of the West Virginia State Medical Association, holds at about the same level as last year. Color is still used extensively by our advertisers, cuts averaging more than thirty per month.

Continued use by our advertising clients of the pages of *The Journal* as a medium of advertising for their products has enabled us to expand appreciably the size of the news and organization sections. We still make every effort possible to keep the balance between reading matter and advertising as nearly as possible on a ratio of 45 and 55 per cent.

The members of the medical profession and officers of affiliated groups, as well as the State Department of Health and various other state and government bureaus continue to furnish us material for news stories which appear in *The Journal*.

The Woman's Auxiliary to the State Medical Association, as well as local auxiliaries, cooperate to the fullest extent in supplying us promptly with news notes concerning the activities of their groups.

We feel that it will be of interest to the members of the State Medical Association to know that the members of the Editorial Board work unceasingly to clear promptly all papers submitted for publication. At all times we have the wholehearted cooperation of the editor, Dr. Walter E. Vest, and the associate editors, Drs. William L. Cooke, R. H. Edwards, George F. Evans, E. Lyle Gage, William M. Sheppe, and Edward J. Van Liere.

### Visits Statewide by the President

Dr. J. C. Huffman of Buckhannon, who has served as president during the past year, has visited practically every section of West Virginia, accepting invitations to speak before both medical societies and local auxiliaries, as well as lay organizations. He has also attended meetings of standing and special committees and has taken an active part in the work that has been done by the various groups during his term of office. The attendance of members of the Council at meetings held during the year has been exceedingly gratifying to the chairman and other officers of the Association. There is a near 100 per cent attendance at each of the meetings.

### Membership by Component Societies

The membership by component societies as of August 15, 1960, was as follows:

| Society | Members |
|---|---|
| Barbour-Randolph-Tucker | 50 |
| Boone | 15 |
| Brooke | 7 |
| Cabell | 164 |
| Central West Virginia | 50 |
| Eastern Panhandle | 40 |
| Fayette | 28 |
| Greenbrier Valley | 36 |
| Hancock | 27 |
| Harrison | 70 |
| Kanawha | 289 |
| Logan | 37 |
| Marion | 52 |
| Marshall | 17 |
| Mason | 11 |
| McDowell | 37 |
| Mercer | 68 |
| Mingo | 25 |
| Monongalia | 54 |
| Ohio | 109 |
| Parkersburg Academy | 93 |
| Potomac Valley | 36 |
| Preston | 16 |
| Raleigh | 86 |
| Summers | 8 |
| Taylor | 8 |
| Wetzel | 13 |
| Wyoming | 12 |
| TOTAL | 1458 |

### Local Society and Auxiliary Aid

It has been necessary for us to call upon officers of component societies and local auxiliaries frequently during the past year for aid in connection with legislation pending in Congress and the West Virginia Legislature. Letters and wires by the hundreds have been sent to our United States Senators and members of the House of Representatives with reference to proposed federal legislation, and the promptness with which the members of our various groups have responded to the request of our Legislative Committee for help has been most gratifying.

*Other annual reports were published in the August, 1960, issue of the Journal.

As usual, the secretaries and treasurers of our component societies have done a splendid job in collecting and remitting state and AMA dues. There was no special assessment during the past year, but, under the By-Laws as amended in 1959, part of the dues are being earmarked for medical scholarships.

### Visitors Always Welcome

Again, we extend a very cordial invitation to all of the members of the State Medical Association and Auxiliary to visit us at our headquarters offices in Charleston. We always seek the opportunity to meet and talk with the members of the two groups, feeling that it is advantageous to us all to become better acquainted.

More of our members have visited us during the past year than during any similar period in the past. This is as we would have it, and we sincerely hope that members of the Association and Auxiliary will continue to drop in to see us whenever the occasion permits.

The members of our headquarters staff join with me in an expression of appreciation for the support that has been accorded us by members of the two groups during the past year.

Respectfully submitted,

Charles Lively,
*Executive Secretary*

Charleston
August 15, 1960

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## Legislative Committee

The activities of the Legislative Committee early in the year were confined principally to the consideration of bills introduced at the thirty-day off-year session of the 54th Legislature which was convened at the Capitol in Charleston on January 14, 1960.

The committee met in Charleston shortly before the first of the year to discuss legislative matters of interest to the medical profession, but it was not until January 28 that any bill directly affecting medicine was introduced in either the Senate or the House.

The bill, S. B. 31, would have made it mandatory for the Medical Licensing Board to issue special permits to graduates of foreign medical schools to practice medicine and surgery in West Virginia for the period of five to eight years. Applicants would have to be accepted to practice in "a hospital" as a house physician under the supervision of the organized medical staff.

As originally introduced, the bill would have required the applicant to be accepted by an "accredited hospital" but the Senate Committee on the Judiciary amended the bill by striking out the word "accredited."

Your committee, at a meeting held in Charleston on January 31, voted unanimously to oppose the enactment of this type of legislation. At that meeting, it was pointed out specifically that passage of the bill would be discriminatory against graduates of American medical schools because of the "poor training" of many foreign graduates. The committee agreed that the bill should also be opposed because its enactment into law would undoubtedly tend to lower standards of medical practice in this state.

On February 4, the Senate, by a vote of 19 to 12 defeated the bill, and earlier that same day the companion bill in the House (H. B. 47) was tabled by the House Committee on the Judiciary.

Members of the Legislative Committee, together with many other interested physicians over the state, made their opposition to the bill known to our representatives in the Senate and the House. Most of the members of the Legislature were seen personally by physicians residing in their home communities, and it was well understood by representatives in both branches why members of the medical profession bitterly opposed enactment of the bill into law.

The 55th Legislature will be convened at the Capitol for its regular sixty-day session on January 11, 1961.

### Forand-Type Legislation Opposed

Since the adjournment of the Legislature, it has been necessary to contact members of the committee and officers and chairmen of key committees of component societies in an effort to enlist the aid of our United States Senators and members of the West Virginia delegation in the House of Representatives in an all-out effort to defeat bills which in any way contain provisions that smack of socialized medicine.

Forand-type legislation has been the target of members of the medical profession the country over, and the physicians of West Virginia have responded in a big way to appeals made for help in contacting members of our own delegation in Congress.

Several bills are now pending that have for their object provision of medical care and hospitalization for our aging population. The medical profession has opposed consistently the enactment of legislation that would in any way connect this matter with our Social Security system.

Your committee has watched with a great deal of concern the developments in Washington since adjournment of the conventions of both major political parties.

We feel sure that practically all of the members of the State Medical Association know that the Senate committee headed by Senator Harry Flood Byrd of Virginia has approved the enactment of a House bill in which the whole matter of medical care for our aged is divorced from Social Security, and we feel that it is unnecessary to list the advantages of this particular bill over the others now pending in the Senate and House.

Your committee appreciates the cooperation of the members of the State Medical Association and Auxiliary in the many important legislative matters that have had to be considered and acted upon during the year.

Respectfully submitted,

Frank J. Holroyd, M. D.,
*Chairman*

Princeton
August 18, 1960

## Medical Economics

Your Committee, through its four sub-groups, has considered and approved several pertinent matters. The new edition of the Workmen's Compensation Manual, so far as it pertains to procedure, was thoroughly studied, and, in conference with the Commissioner, several changes of interest to the medical profession were discussed and accepted.

The Commissioner has informed our Committee that suggested changes in the Manual are acceptable and that a new fee schedule, with an average 8 per cent increase, would be effective about September 15, 1960.

An increase in the DPA medical fee schedule has been effected, and several minor matters at question in the medicare program have been satisfactorily adjudicated.

By far, the greatest amount of activity has been in the study of a program to provide adequate medical care for our plus-65 citizens in a manner acceptable to the standards of our profession. When this study was begun last year, the only legislation offered was the Forand Bill. We were convinced that the administration and Congress would not accept such a bill, which had already been condemned by organized medicine. This condition left but one possibility—we men of medicine were morally obligated to propose a concrete method of providing such care in a manner acceptable to the public and the medical profession, and by means of which the plus-65 persons with limited income could provide a minimum prepaid method of financing such costs.

Although there are no definite figures available anywhere in the United States, I have estimated that we have in West Virginia about 150,000 persons 65 years of age or older. Based upon national figures, 9 per cent of this number, or 13,500, enjoy incomes which enable them to finance their own medical costs, and 60 per cent, or 90,000, are receiving social security benefits averaging $72.00 per month. About 20,000 persons are on old age assistance. This leaves about 117,500 citizens in the marginal income group, to whom any but minor illness is a catastrophe, and the cost and payment thereof is of direct interest to the medical profession.

With these facts in mind, your Committee decided to investigate means of providing minimal prepaid coverage and arbitrarily set the gross annual income limits at $2,000 per single person, and $3,000 per couple.

We have had several conferences and voluminous correspondence with the eight Blue Cross-Blue Shield plans in this state. Each of these plans have what is called a standard Plan A contract which is a service contract for citizens with limited incomes and also indemnifies subscribers with more adequate annual income in the amounts specified in their schedules.

Because of the fact that we were dealing with a contract which would be paid for by the low income plus-65 person without any financial assistance from federal, state, or other sources, we decided upon a contract which would provide 75 per cent of the fees set forth in the service schedule, under the premise that medical men would be willing to make this contribution to the public welfare.

We found that plus-65 persons use medical and hospital services two and a half times more than younger persons. Early in our negotiations we learned there was little or no disposition on the part of hospitals to make even slight concessions in their proposed benefits and fee schedules.

In brief, quotations we have received from Blue Cross-Blue Shield plans in the state would provide for an average monthly cost of $6.50 to $7.50 for hospitalization, and from $1.90 to $2.50 per person for medical and surgical benefits.

In the belief that competition might be advisable, the largest commercial carrier, Mutual of Omaha, was asked to submit cost and benefit schedules. Its costs for comparable services would be $7.50, and $2.50 per person per month.

At this time the picture changes. House Bill 12580 which would provide medical and hospital care for plus-65 persons upon a contributory basis was passed on July 2, 1960. The services were much more extensive than had been figured in our local state plan. The cost of this program in its first year was estimated at $144,000 for the Federal government, and $78,000 for the state of West Virginia.

Then came the political conventions with a radical difference in party platforms so far as this problem is concerned. Last week Senator Javits introduced an amendment to H.B. 12580 which was in line with administration principles and which would be acceptable to organized medicine. Senator Anderson introduced an amendment, Forandian in its conceptions, which would offer greatly expanded benefits to be financed through the Social Security Agency. Both of these amendments were defeated, 67-28 and 51-44, on August 22. Later the same day an amendment providing for both federal and state participation was passed 89-2.

I shall, at the first session of our House of Delegates on Wednesday evening, August 24, ask unanimous consent to introduce the following resolution pertinent to this report:

> "WHEREAS, By reason of federal and state legislative action, the element of time is an important factor in any program that might be developed for the care of our aged citizens:
>
> "THEREFORE, BE IT RESOLVED, That the House of Delegates of the West Virginia State Medical Association adopts in toto the report of the Committee on Medical Economics presented at the first meeting of the House of Delegates on Wednesday evening, August 24, 1960, and authorizes the Committee to continue its studies in the whole field of medical care for the aging; and,
>
> "BE IT FURTHER RESOLVED, That the Council of the West Virginia State Medical Association be requested, with the advice of pertinent committees, to activate any negotiations or legislative action designed to further the objects of this resolution; and,
>
> "BE IT FURTHER RESOLVED, That representatives of the Committee on Medical Economics be authorized to attend and participate in the Governor's Conference on Aging which will be held at Morris Harvey College, in Charleston, September 1-2, 1960."

The chairman would be glad to receive from any of our members prior to the 1961 session of the Legisla-

ture suggestions regarding proposed state legislation concerning medical care of the aging, especially with reference to qualifications, administration, personnel and type of pre-paid coverage.

Respectfully submitted,

James S. Klumpp, M. D.,
*Chairman*

White Sulphur Springs
August 24, 1960

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## Necrology Committee

The following is a list of West Virginia physicians whose deaths have been reported to the West Virginia State Medical Association during the past year:

**1959**

| | |
|---|---|
| Aug. 11—Benjamin A. Smith | Huntington |
| Aug. 15—Earl F. Glass | Wheeling |
| Sept. 22—Keith E. Gerchow | Morgantown |
| Sept. 24—Frank Hogan Penn | Mullens |
| Sept. 28—William P. Jamison | Rowlesburg |
| Oct. 5—James Chapman Repass | Lumberport |
| Oct. 10—Virgil L. Kelly | Bluefield |
| Oct. 17—Thomas Martin Goodwin | Elkins |
| Oct. 22—Wilbur Emory Hoffman | Charleston |
| Nov. 4—John A. McCurdy | Wheeling |
| Nov. 6—James Adam Rusmisell | Buckhannon |
| Nov. 10—John Wesley Smith | Gassaway |
| Nov. 12—Will E. Neal | Huntington |

**1960**

| | |
|---|---|
| Jan. 6—Carl Edgar Morehead | Parkersburg |
| Jan. 11—Dorsey C. Beall | Morgantown |
| Jan. 20—George Preston Daniel | Glen Daniel |
| Feb. 5—Charles W. Petty | Atlanta, Georgia |
| Feb. 20—Charles Newton Brown | Marietta, Ohio |
| Feb. 23—James Edward Hubbard | Baltimore, Md. |
| Feb. 29—William B. MacCracken | Huntington |
| Mar. 11—James Wood Frazier | Charleston |
| Mar. 16—Walter N. Rowley | Huntington |
| Mar. 26—Scioto P. Walker | Huntington |
| Apr. 6—William Archibald Flick | Keyser |
| Apr. 25—George Phillips Evans | Largo, Fla. |
| Apr. 29—James Kennedy Stewart | Wheeling |
| May 14—Edgar B. Le Fevre | Inwood |
| May 20—Richard V. Shanklin | Bluefield |
| May 27—Samuel H. Burton | Weston |
| June 19—Frank Judson Moore | Beckley |
| June 22—Harlow R. Connell | Bluefield |
| July 21—Charles L. Parks | Fairmont |
| July 21—S. D. H. Wise | Washington, D. C. |
| July 28—Sylvester P. Allen | Webster Springs |
| Aug. 10—Dwight P. Cruikshank | Lumberport |
| Aug. 17—Harry T. Schiefelbein | Welch |

Respectfully submitted,

J. M. Cofer, M. D.,
*Chairman*
W. L. Neal, M. D.
Charles N. Slater, M. D.
J. H. Wolverton, M. D.

White Sulphur Springs
August 24, 1960

## Social Security Coverage for Physicians (Special Report)

I have been asked by your President, Dr. J. C. Huffman, to report to you on the present status of legislation on Social Security Coverage for Physicians. The report is to cover both recent actions of the House of Delegates of the American Medical Association and our Federal Government.

In April 1959, at the direction of the Council, the entire membership of our Association was polled on the subject of Social Security coverage. Of the 715 cards which were returned out of a total number of 1452 which were mailed, approximately 2 for 1 expressed approval of the idea of Social Security coverage. This report was presented to the Council on July 16, 1959. The question was raised among the members of the Council as to just how many of our physicians were paying into Social Security at the present time and as to the wisdom of having a more detailed poll.

Pursuant to a resolution adopted by the House of Delegates during the 1959 Annual Meeting, a poll was conducted among the membership of the Association to determine (1) the number of members over the age of 65 years, (2) the number now receiving Social Security benefits, (3) the number paying into Social Security, and (4) the type of practice of the members. Of the 872 members who participated in the poll out of a total membership of 1459 as of September 1, 1959, 23.5 per cent indicated that they were paying into Social Security while 2.9 per cent said they were receiving Social Security benefits.

During the June 1959 meeting of the House of Delegates of the American Medical Association which was held in Atlantic City, three state delegations offered resolutions in which they asked for AMA approval of Social Security coverage. They pointed out that a recent poll showed a majority of the members were in favor of such coverage.

Your West Virginia delegation offered a resolution that the House give serious consideration to the results of the West Virginia poll which showed that a "sizable majority" of physicians in the state were in favor of Social Security coverage, and similar polls when reviewing the American Medical Association's policy on Social Security coverage for physicians.

The Georgia delegation urged the House to reaffirm its traditional stand in opposing the compulsory inclusion of self-employed physicians under Social Security.

During the hearing of the Reference Committee on Legislation and Public Relations which considered these resolutions, 28 physicians spoke in opposition of coverage; five spoke in favor. Your delegation testified as to the results of the recent poll of physicians in our state.

The Reference Committee recommended to the House that those resolutions including that of West Virginia, which asked for reversal of the AMA stand, be not approved and the resolution offered by the delegates from Georgia be approved. This recommendation was approved by the House.

The Reference Committee, in its report, made the following points:

1. The Reference Committee was informed that many states have conducted polls on this subject, but that all but one of these polls were subjected to severe challenge. In addition, it felt that some physicians who participated in the polls may not have been in possession of the type of data brought out in the discussion before the committee. Therefore, it would be unfair for the House, even though some might desire Social Security coverage, to force it on others who wish to plan for their retirement on a private insurance basis.

2. Twenty-eight physicians spoke in opposition to coverage at the hearing; five in favor.

3. The Reference Committee considered the question of whether Social Security was a true "insurance" program. It was brought out that the U.S. Supreme Court has held that Social Security is not an "insurance" program. It was also brought out that Social Security is basically a tax program in which the taxpayer has no vested right in the benefits.

4. The Reference Committee felt that consideration must be given to the possible effects that a change in the American Medical Association's policy regarding Social Security would have upon the entire legislative program of the AMA.

5. The Reference Committee suggested to the House that it request the Board of Trustees to investigate the possibility of developing a group insurance and retirement plan which could be made available to its members.

There were no resolutions on Social Security coverage for self-employed physicians at the Clinical Session in Dallas in December 1959.

At the Annual Meeting of the AMA in Miami Beach in June 1960, the Georgia delegation submitted Resolution 4, which urged the House to reaffirm its opposition to the inclusion of physicians under OASDI coverage. It also called on the AMA to continue its efforts in making this stand known to all members of Congress.

The Reference Committee on Legislation and Public Relations which discussed this resolution reported to the House:

> "The discussion indicated that there had been no real change in opinion on this matter since the Annual Meeting in Atlantic City in June 1959. Your Reference Committee recommends that this resolution be approved, thus reaffirming the opposition of the House of Delegates to the compulsory inclusion of physicians under Title II of the Social Security Act."

This report was approved by the House.

As for the situation in Congress: At the beginning of the present session, the Mills Bill (H.R. 12580), which contains a Federal-state approach to meeting the problems of the health care of the aged and also a provision for compulsory coverage of physicians under Social Security, is still in the Senate Finance Committee. Although the Committee held two days of hearings on the bill, it is likely to hold hearings on the measure again in August.

With reference to the group annuity program, H.R. 10 would permit self-employed physicians to establish a tax-deferred pension plan. It will be one of the bills to be taken up by the Senate during the present session.

The Senate Finance Committee deleted social security coverage for physicians from the House-approved bill (H.R. 12580). This action has now been approved by the Senate as a whole. It still remains to be approved by a Conference Committee of the two houses of Congress and then finally accepted by the House. This, however, seems to be a foregone conclusion.

Respectfully submitted,

Charles A. Hoffman, M. D.

White Sulphur Springs
August 24, 1960.

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## Advisory Council, DPA Medical Services Fund (Special Report)

The Public Welfare Law of West Virginia was enacted by the Legislature in 1936 and amended in 1937 and again in 1959. The act provided for the creation of a State Advisory Board to be composed of five members appointed by the Governor by and with the advice and consent of the Senate. Not more than three of the members of the State Advisory Board, other than the director, may belong to the same political party. Members are appointed for a term of six years, and meetings are held regularly four times a year. It is the duty of the State Advisory Board to recommend to the Governor at least two persons for each vacancy in each County Council.

Article 4 of the law states that the County Public Assistance Council shall be composed of five citizens of the county, of whom four shall be appointed by the Governor upon recommendation of the State Board. The president of the county court is a member ex officio. Not more than three members may belong to the same political party. Members of the Council serve without compensation for a term of three years.

Article 5 creates an "Advisory Council for the State of West Virginia Public Assistance Medical Services Fund" composed of six members who meet at least twice a year. Five of the members of the Advisory Council are appointed by the director. The sixth member is the State Director of Health, ex officio.

The Advisory Council of the DPA Medical Services Fund met in Charleston, July 20, 1960, with the following members present: N. H. Dyer, M. D., Mr. Dewey Bailey, Mr. Charles Showalter, Dr. J. W. Dixon, Jr., Miss Juliann Ritter, and L. Dale Simmons, M. D.

Others present were Mr. Thomas R. Egbert, Mr. Harley R. Hedge, Mr. J. Patrick McCarthy and Mrs. Lelia Fay.

The Medical Services Fund was created in 1956. Since that time counties have made payments into the Fund on a premium per case basis. These payments are placed in a pooled fund and augmented with Federal funds only in four categories: Old Age Assistance, Aid to the Blind, Aid to Dependent Children, and Aid to the Permanently and Totally Disabled.

During the last fiscal year expenditures from the Fund totaled more than $2 million, with a breakdown as follows: Hospitals, 73 per cent, Medical, 20 per cent, Drugs, 3 per cent, Dental, 2 per cent, and Others, 2 per cent.

The Fund was made up of contributions from the Federal government, 49 per cent, State, 37 per cent, and County, 14 per cent. The adequacy of the Medical Services Fund to meet the needs is determined primarily by appropriations made by the Legislature. The amount of federal money needed for medical services for indigent individuals could be doubled or possibly tripled, but state funds must be made available first. All money in the Fund is earmarked for services, and none for administration.

As a member of the Advisory Council, I entered a complaint concerning the long and time-consuming medical report Form D2 required by the DPA for eligibility, so a special committee was set up to revise the form, and as a member, I am now working on this revision.

The fee schedule has been revised. The fee for house calls from 8 A.M. to 8 P.M. is now $4.00, and from 8 P.M. to 8 A.M., $5.00. The mileage allowance is ten cents a mile. Office visits are now initially $3.00, with $2.00 for subsequent visits. The fee for non-surgical hospital visits is $2.00 per day.

The possibility of increasing the medical fee schedule, particularly surgical fees, was discussed by the Council, and the members appeared to be sympathetic to the proposal. Mr. McCarthy said that the State Medical Association has never stated publicly that an increase was desired and that he believed that the Department would be in a much better position if the Association would adopt a definite policy on the subject and follow through with support in the Legislature.

Mr. Egbert asked if county societies would be interested in setting up a three-man advisory committee to which the county director could go for help. He was told that such committees already were in existence and would be willing to cooperate.

Mr. McCarthy discussed pilot studies that are under way in some counties to determine length of hospitalization in connection with the submission of ten and five-day forms authorizing longer hospitalization. He expressed the opinion that hospital stay could probably be decreased by requiring a five-day extension notification.

It is my opinion that the basic difficulty between the State DPA and physicians is misunderstanding, and I submit the following recommendations:

(a) After the November election seek representation on the State Advisory Board, there being two vacancies at the present time;

(b) Seek representation on each County Council through the State Board; and,

(c) Assist in obtaining increased appropriations for the DPA from the Legislature.

Respectfully submitted,

L. Dale Simmons, M. D.,
Member, Advisory Council,
DPA Medical Services Fund.

Clarksburg
August 21, 1960.

# Resolutions

The Committee on Resolutions conducted an open hearing on Thursday afternoon, August 25, on the two resolutions offered in the House of Delegates the previous evening. The resolutions follow:

**Resolution No. 1. Increase in Dues for the Benefit of the AMEF—By W. L. Neal, M.D., Chairman, Committee on American Medical Education Foundation.**

WHEREAS, It has come to our attention that medical schools in the United States now have an annual operating deficit of ten million dollars; and,

WHEREAS, Except for one-time building grants, it has been deemed unwise to solicit financial support from the Federal Government; and,

WHEREAS, The American Medical Education Foundation has received annually since its creation in 1951 about one million dollars in unrestricted grants to approved medical schools and it now appears that at least twice that amount is needed annually for distribution to such schools; and,

WHEREAS, In recent years about 12 per cent of the physicians in West Virginia have contributed an average of $35 each year, for a total of approximately $7500, and while experience in other states has shown that the only way to obtain full-measured support of all the members of any medical society or association is by an increase in dues or by an annual special assessment; and,

WHEREAS, Your AMEF Committee would like to urge a one hundred per cent participation in the program by the members of the West Virginia State Medical Association:

THEREFORE, BE IT RESOLVED, That the annual dues of the West Virginia State Medical Association be increased in an amount which should provide approximately $13,000 each year for the AMEF.

* * * *

**Resolution No. 2. Participation by the Medical Profession in a Program for Medical Care of our Older Citizens—By James S. Klumpp, M.D., Chairman, Committee on Medical Economics.**

WHEREAS, By reason of federal and state legislative action, the element of time is an important factor in any program that might be developed for the care of our aged citizens:

THEREFORE, BE IT RESOLVED, That the House of Delegates of the West Virginia State Medical Association adopts in toto the report of the Committee on Medical Economics presented at the first meeting of the House of Delegates on Wednesday evening, August 24, 1960, and authorizes the Committee to continue its study in the whole field of medical care for the aging; and,

BE IT FURTHER RESOLVED, That the Council of the West Virginia State Medical Association be requested, with the advice of pertinent committees, to activate any negotiations or legislative action designed to further the objects of this resolution; and,

BE IT FURTHER RESOLVED, That representatives of the Committee on Medical Economics be authorized to attend and participate in the Governor's Conference on Aging which will be held at Morris Harvey College in Charleston, September 1-2, 1960.

### Disposition of Resolutions by Committee

The Committee first considered Resolution No. 2, and it was approved without a dissenting vote.

Resolution No. 1 concerning contributions to the American Medical Education Foundation was discussed by the Committee and several physicians who were present. Objection was voiced to an increase in dues at the present time, as well as to the levying of a mandatory assessment against all members of the State Medical Association. The Committee, in executive session, approved a voluntary assessment of $10 for the AMEF.

### House Acts Upon Recommendations

The Chairman of the Committee, Dr. Albert C. Esposito of Huntington, submitted his report to the House of Delegates at the final session on Saturday afternoon, August 27.

Resolution No. 2, offered by James S. Klumpp, M.D., of Huntington, reported out favorably by the Committee, was unanimously adopted.

Resolution No. 1, by Dr. W. L. Neal of Huntington, was amended by the Committee by changing the resolving clause so as to provide for a voluntary assessment of $10 for the AMEF to be levied against each dues-paying member of the State Medical Association. Provision was made for the designation by a member of a school of his choice to receive his contribution, undesignated funds collected to be earmarked for the West Virginia University School of Medicine. The resolution as amended by the Committee was unanimously adopted.

### Report of Resolutions Committee

The complete report of the Resolutions Committee follows:

Your Committee on Resolutions has carefully considered the resolutions offered before the first session of the House of Delegates on Wednesday evening, August 24, 1960.

Several members of the Association appeared at a meeting of the Committee held on Thursday afternoon, August 25, 1960, and discussed in detail the resolutions then pending. The cooperation of these physicians has been most helpful to the Committee in reaching decisions, and we express appreciation to those who took time to attend the open hearings.

Resolution No. 1, providing for an increase in dues for the benefit of the American Medical Education Foundation, offered by W. L. Neal, M.D., of Huntington, Chairman of the AMEF Committee, was considered first by the Committee at the conclusion of the open hearings.

The Committee voted unanimously to recommend the deletion of the resolving clause of the resolution and the insertion of the following in lieu thereof:

> THEREFORE, BE IT RESOLVED, That a voluntary assessment of $10 for the American Medical Education Foundation be levied against each dues-paying member of the State Medical Association, to be collected by the component societies at the time of the collection of the annual dues, and remitted directly to the AMEF offices in Chicago; and,

BE IT FURTHER RESOLVED, That individual members of component societies may have the privilege of designating the schools of their choice which are to receive their contributions, and that any undesignated funds collected by component societies shall be earmarked for the West Virginia University School of Medicine.

Resolution No. 2, offered by James S. Klumpp, M.D., of Huntington, Chairman of the Medical Economics Committee, concerning participation by the medical profession in a program for medical care of our older citizens. The Committee voted unanimously to recommend the adoption of the resolution.

Your Committee assures the members of the House of Delegates that the one and only consideration that has guided the members in their deliberations has been the criteria as to whether each of the resolutions, as well as the resolutions offered last year, were or would be to the best interests of the entire medical profession in West Virginia.

Again, we wish to thank the members of the West Virginia State Medical Association who appeared before the Committee at the open hearing on August 25.

Your Chairman personally expresses his gratitude to the members of the Committee for the patience, enthusiasm, wisdom and valuable time devoted to the study of the resolutions.

In addition to your Chairman, the members of the Committee participating were Drs. Richard W. Corbitt, Parkersburg; Maynard P. Pride, Morgantown, Pat A. Tuckwiller, Charleston; G. Thomas Evans, Fairmont; Charles L. Leonard, Elkins; and Charles Lively, secretary ex officio, and William H. Lively, executive assistant.

**Proposal for Increase in Dues Withdrawn**

At the first session of the House, Dr. W. L. Neal of Huntington, Chairman of the AMEF Committee, offered an amendment to Sec. 6 of Chap. I of the By-Laws providing for an increase in dues of members of the State Medical Association from $35 to $45 per annum. It was explained that the additional ten dollars which would be collected would be earmarked for the AMEF.

Immediately preceding the consideration of the report of the Resolutions Committee on Saturday afternoon, August 27, Doctor Neal, with the consent of the House, withdrew the proposed amendment.

**Courtesy Resolutions Adopted**

Dr. James S. Klumpp asked and obtained the unanimous consent of the House for the introduction of three courtesy resolutions. The resolutions which follow were adopted unanimously.

**Resolution No. 3. Appreciation for Cooperation of Personnel at The Greenbrier.**

WHEREAS, The natural beauty of White Sulphur Springs, the splendor of The Greenbrier, and the complete and courteous attention afforded us are always anticipated with much pleasure; and,

WHEREAS, We medical men of West Virginia are indeed fortunate in the enjoyment of such an atmosphere at our annual meeting:

THEREFORE, BE IT RESOLVED, That the Executive Secretary be directed to express our sincere thanks to the management and entire staff of the Greenbrier Hotel for the many courtesies and services shown to the members of the West Virginia State Medical Association, our families and guests, during our 93rd Annual Meeting.

* * * *

**Resolution No. 4. Coverage By News Media of All Sessions at Convention.**

WHEREAS, At each annual meeting, the pertinent, informative and interesting details are ably transmitted to the general public by radio, TV, press and wire facilities, thus affording us the opportunity of sharing our thoughts and actions with those we serve:

THEREFORE, BE IT RESOLVED, That the Executive Secretary be directed to extend our sincere thanks to these media of communication, with especial attention to the Associated Press, United Press International, The Charleston Daily Mail and The Charleston Gazette.

* * * *

**Resolution No. 5. Distribution Daily of Morning Paper During Convention.**

WHEREAS, As we leave our quarters each morning, we find a copy of the daily newspaper awaiting our leisurely perusal during the morning hours which over the years has become one of the pleasant features associated with the Annual Meeting:

THEREFORE, BE IT RESOLVED, That the Executive Secretary be directed to extend the thanks of our members and guests to the Hospital and Physicians Supply Company of Charleston for this friendly courtesy.

The West Virginia Medical Journal

November, 1960 Vol. 56, No. 11

# Prematurity: Obstetrical Aspects*

*Anthony Ruppersberg, Jr., M. D.*

Today we enjoy life in a magnificent era to be identified in history as one revealing great progress. This progress we are proud to say is not confined to power, transportation and material things, but is displayed also in the various fields of medicine.

In our favorite branch of medicine, obstetrics, progress is marked by a heroic reduction in maternal deaths. United States Vital Statistics records disclose a drop of 93 per cent in maternal deaths over a 42-year period (61 per 10,000 live births in 1915, to 4.3 per 10,000 in 1957). This has been accomplished through numerous efforts, most of which are based on advances in education.

Closely allied to success in obstetrics is infant survival. Infant mortality in the United States in 1915 was extremely high; statistics reveal that for every 10 infants born alive at that time, one died in the first year of life. Cooperative efforts have reduced appreciably this high rate due to diarrhea and infection. But, for example, in New York from 1945 to 1955 the infant mortality dropped only 16 per cent (31 per 1,000 live births to 25.8 per 1,000) while the maternal mortality was reduced 70 per cent.[2]

It has been shown that more than half of the early infant deaths occur in babies born prematurely. It seems logical, therefore, that we open a discussion at this point concerning the incidence, etiology and prevention of premature births.

### Terminology

Many groups of statistics have been compiled from time to time about prematurity. A lack of uniformity in nomenclature and terminology plagued the conscientious worker who tried to develop helpful data concerning the "small baby." The poor quality of information on stillbirth and death certificates has proven to be a great hindrance; there is need for more accuracy in the entries under cause of death and birth weight if progress is to be realized.[17] Furthermore, since it is known that weight is the accepted criterion for the diagnosis of prematurity, an adjustment must be made in certain instances where this weight is considered with race and environmental status of the mother.

Fetal age or prenatal maturity usually is estimated by the obstetrician after an evaluation of three factors: (1) length of gestation, based on the beginning date of the last menstrual period, (2) clinical size of the uterus and the fetal ovoid within it and (3) conscientious appraisal of x-ray findings of the uterine contents.

In recent years an attempt has been made to approach uniformity in terminology applied to "premature babies." The World Health Organization, in 1948, established a standard birth weight of 5.5 lbs. (2,500 Gm.) or less.

This year the American Medical Association, in cooperation with 12 other national organizations, published an excellent booklet titled "A Guide for the Study of Perinatal Mortality and Morbidity."[1]

Among other valuable points of information this booklet establishes in fetal deaths a classifica-

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*Presented before a Seminar on "Prematurity and Infections in Newborns," sponsored by the Division of Maternal and Child Health, State Department of Health, at Clarksburg, W. Va., November 19, 1959.

Submitted to the Publication Committee, April 5, 1960.

tion of "premature babies": those with a birth weight of from 1,001 Gm. to 2,500 Gm., corresponding to 28 to 36 weeks of uterogestation. The relation to this portion of the over-all picture is shown in Table 1. Acceptance of this terminology as a standard, marks a distinct advance which will benefit future research along these lines.

Other factors, of necessity, will be integrated into certain exceptions to this practical standard; for example, Verhoestraete and Puffer[17] found that in the Netherlands, Denmark and Norway, where average birth weights are higher, the range in the frequencies of prematurity is very great.

**TABLE 1**

**CLASSIFICATION OF FETUSES, AND FETAL DEATHS BY WEIGHT AND BY WEEKS OF GESTATION[1]**

| *Fetal Weight* | *Weeks of Gestation* |
|---|---|
| I. Early Fetal Death<br>Conception to 500 gms. (1# 1 oz.) | Conception to 20 wks. (Abortuses) |
| II. Intermed Fetal Death<br>501 gms. (1# 2 oz.) to 1000 gms. (2# 3 oz.) | 20-27 wks. (Immature) |
| III. Late Fetal Death<br>1001 gms. (2# 4 oz.) to 2500 gms. (5# 8 oz.) | 28-36 wks. (Premature) |
| 2501 gms. (5# 9 oz.) and over 3500 gms. (7# 11 oz.) | 36-40 wks. or more (Mature) |

**Incidence**

Statistics concerning the incidence of prematurity (premature birth) are fascinating. Their variability, however, due to different denominators of inclusion makes it difficult to focus a clear picture of the actual occurrence.

In Ohio, during 1958 (Table 2), there were 69.8 live premature births per 1,000 live births (7 per cent); it is further reported that the rate rose to 75.6 per 1,000 live births (7.6 per cent) when all infants below 2,500 Gm. were included.[7] State statisticians frequently are hampered in their calculations by a lack of complete information on the standard birth and fetal death certificates, e. g., birth weight is omitted all too often. In Table 2 (Ohio column) 1,436 infants had no birth weight recorded.

Also during 1958, in Columbus, Ohio, a metropolitan city of one-half million population, among 19,594 resident births 1,735 premature infants were born; there were 149 premature stillbirths in this total (Table 2). The premature mortality rate for 1958 was reported to be 16.8 per cent of the premature births, whereas the mortality rate for mature babies was 1.13 per cent.[5]

Taylor and Walker[16] found the incidence of prematurity to be 13 per cent of all infants over 1,000 Gm. in weight. In nine hospitals, from New Orleans to New York, Nesbitt[12] observed that premature births comprised from 7 per cent to 12 per cent of all live births.

Baumgartner[2] declared that more than half of the early infant deaths occur in babies born prematurely. She further presented a seven-year comparison stating that in New York City, during 1948, 8.8 per cent of babies born alive weighed 2,500 Gm. or less, while in 1955, 9.2 per cent of babies born alive weighed 2,500 Gm. or less; "judging by the data on birth weights, no gains have been made in curbing premature births."

From a world view, Verhoestraete and Puffer[17] declare that the condition of the infant at the time of birth is influenced by his maturity; prematurity plays an important role in death. Nesbitt[12] found that "premies" accounted for 54 per cent of the perinatal mortality among 566 cases at Johns Hopkins Hospital.

Bundeson (cited by Stephens[15]) states that 79.1 per cent of the natal-day deaths in Chicago are due to prematurity. "Thus, it seems obvious that a further reduction of perinatal mortality is keyed to a reduction in premature deliveries."

**Etiology**

The causes of prematurity and premature births are numerous. Reliable observers have assigned varying degrees of importance to the wide variety of factors associated with or contributing to the arrival of the "small baby." It seems in order to enumerate these factors briefly before we discuss prevention and management.

**TABLE 2**

**RESIDENT BIRTHS, PREMATURE LIVE AND STILLBIRTHS, 1958**

| *Classification* | *Ohio*[7] | *Columbus*[5] |
|---|---|---|
| Total Births | 237,575 | 19,594 |
| Live Births: | 234,040 | 19,318 |
| Premature (1000-2500 gms) | 16,343 | 1,586 |
| Unknown weight | 476* | ..... |
| Stillbirths: | 3,535 | 276 |
| Premature (1000-2500 gms) | 875 | 149 |
| Unknown weight | 960* | ..... |
| Premature deaths | | 267 |
| Premature Mortality Rate | | 16.8** |

*Excluded in Totals.
**Per cent of Premature Births.

A. *General.* Among predisposing factors Bundeson cited by Ruppersberg[14] lists age, of mothers under 20 years and over 40 years. Baumgartner[2] observed that mothers pregnant out of wedlock (5.5 per cent of all births) frequently failed to obtain prenatal care and their births were associated with a higher incidence

of prematurity; likewise, mothers living on a poor, deficient diet had babies with a lower birth weight. Premature births and fetal mortality rates were found to be much higher among lower socio-economic groups by several authors[2, 4, 9, 17]. Emotional factors are believed also to cause the onset of premature labor.[10]

B. *Maternal.* Among the nonobstetric causes of prematurity severe maternal illness has been accepted for years as a contributing factor (syphilis, cardiac disease and hypertension, pneumonia, and tuberculosis).[12] Myomata and pelvic abnormalities (uterine hypoplasia) are mentioned, as well as endometrial deficiencies[9] and reduced uterine circulation.[3]

As a prominent factor in the cause of prematurity, the incompetent cervix has been discussed recently[8, 13, 16] although the total number of cases selected to date is relatively small. Picot[13] estimates that the incompetent cervix occurs about three times in 1,000 pregnancies. Likewise, a small per cent of premature births (0.4 per cent to 5.2 per cent) may be precipitated by maternal trauma.[12]

The obstetric causes of prematurity seem to fulfill a more concrete role; they constitute the primary problems connected with fetal salvage. Ascending infections[9, 12] secondary to trichomonas or monilial invasion of the vagina are prone to produce amnionitis and endometritis followed by premature labor with a potentially infected fetus. Diabetes,[12] although not a direct obstetric cause of prematurity, is listed because of its close association with toxemias and polyhydramnios. It becomes the occasional indication for termination of pregnancy before the 36th or 38th week of gestation.

The toxemias[4, ,9 12] vary in incidence from 3.5 per cent to 29.9 per cent as causes associated with premature birth. Fish[4] and his group found polyhydramnios in 11 of 347 cases of prematurity, with only 2 cases of premature rupture of the membranes. Multiple pregnancies varied as a cause of premature labor from 6.3 per cent to 22.9 per cent in nine hospitals, according to Nesbitt.[12] This observation has been corroborated by most of us.

Hemorrhage as a cause associated with prematurity bears little room for controversy. Abruptio placentae and placenta previa with separation, are listed by most authors[4, 12] as etiology for the onset of premature labor. Fish and associates[4] found, however, ruptured marginal sinus the only demonstrable lesion associated with premature labor in 70 of 347 premature births; bleeding may be visible or concealed.

Accidental premature rupture of membranes, long proven as a common axiom in etiology, is reiterated[9, 12]; labor usually ensues in a variable length of time.

Closely allied is elective induction of labor; usually maternal diabetes, toxemia, hemorrhage, or "convenience" is the indication for this procedure. Lovett,[9] with reference to the latter, states, "Delivery of a premature infant after elective induction of labor is an inexcusable error." Along the same vein of reasoning lies another cause of premature birth, repeat cesarean section. Fish and his group[4] declare that misjudgment of the patient's "due date" constitutes the major problem. Grossman and Benson[6] likewise agree that prematurity, the result of ineptly timed elective cesarean section, is the largest single factor in fetal mortality. Lovett[9] recommends waiting for labor to commence, or confirming fetal size by x-ray, if the section be strongly indicated.

C. *Fetal.* The fetal causes for premature birth are less numerous. Malformation of the fetus and erythroblastosis certainly are not obstetrical factors. Nesbitt[12] lists further as specific fetal causes associated with prematurity the following, which he observed among 435 cases: anoxia, abnormal pulmonary ventilation, birth injuries and infection. Anoxia and abnormal pulmonary ventilation as causes for fetal death in the premature infant may be charged also to obstetrical factors such as excessive medication, anesthetic agents, traumatic procedures during delivery and maternal vaginal infections.

D. *Demonstrable Cause.* In the final category following a critical analysis of all causes of "prematurity," let us balance our scales of information.

1. A definite cause for premature labor and premature birth may be demonstrated, on an average, in from 30.7 percent to 38 per cent of cases.[12] Causative factors often vary directly with the care we exercise in a methodical search for them.

2. No cause for premature labor is demonstrable in 60 per cent of cases (Eastman cited by Baumgartner[2]). Nesbitt[12] found no etiological condition associated with premature birth in from 30.7 per cent to 64.7 per cent of cases in nine hospitals.

On the other hand, it has been pointed out that mortality among premature infants is higher when they are delivered from mothers who developed a complication of pregnancy.[18] To support this contention Taylor and Walker[16] discovered that premature infant mortality was 26 per cent when the mother had complicated pregnancies, whereas it was 7 per cent in the

uncomplicated pregnancy. Neonatal death rates among premature infants followed a similar pattern.

In summary, the etiology of premature birth appears to be accompanied most frequently by maternal disease or obstetrical complications; conversely, the future reduction of infant deaths associated with "prematurity" must await the further elimination of obstetrical pathology.[4, 16]

**Prevention**

Taylor and Walker,[16] after investigation, declared that 1/5 of the deaths among premature infants can be prevented with present day medical knowledge and skill.

In the Franklin County (Ohio) Perinatal Mortality Study during 1958, Williams and Shaffer[19] reported 131 premature deaths among 297 infant deaths. The Committee voted 30.5 per cent of the premature deaths preventable. Of the 40 preventable premature cases, 15 (37.5 per cent) were "OB preventable," 16 (40.0 per cent) were "PED. preventable" and 9 (22.5 per cent) were voted "PATIENT Preventable."

In the New York Study, Baumgartner[2] found 35 per cent of the perinatal deaths preventable. Judging the incidence of premature birth and its profound contribution to total fetal mortality, we must strive to obliterate prematurity.[14] Steps to achieve this goal may be divided into prevention of premature labor and delivery and salvage of the fetus after onset of labor.

Little advance in knowledge has been made regarding how to prevent premature labor, principally because scattered clinical observations do not furnish an adequate understanding of the mechanism precipitating early labor.[2] Until such time as these problems are solved we must aim to reduce etiology at various specific points.

1. Regardless of the patient's age, marital status or socio-economic situation, she is entitled to receive adequate prenatal care. A well rounded educational program sponsored cooperatively by the medical profession and the health department teaches patients to register early and to follow prenatal care conscientiously. Counselling the patient usually allays anxiety and apprehension, and reduces emotional disturbances, producing a more confident, cooperative patient. The medical profession should be prepared to meet the challenge and provide a high level of good obstetric care in all of its implications.

2. A carefully prepared history, meticulous physical examination and proper laboratory studies usually reveal the nonobstetric causes associated with prematurity. Prompt recognition and immediate treatment should be automatic features of the program. Cardiac cases should be managed on a basis of (a) maternal survival and (b) fetal salvage. Patients with cardiac disease or diabetes should receive extra care of a specialized type.

3. The incompetent cervix may be considered for early surgical treatment in certain selected cases. Picot et al[13] chose to operate in the second trimester (never before the 16th week of gestation); using the modified Shirodkar technique he reported 26 surgical cases, with four failures. Thus, pregnancies with a previous history of early termination were carried to the 34th or 39th week; delivery was accomplished by cesarean section. Lewis and Reed[8] report three cases, using a nylon suture and polyethylene tubing instead of a fascia lata transplant. Very recently, Taylor and Hansen (JAMA 171:1312-1315 (Nov.) 1959) announced satisfactory results in 32 of 40 cases of incompetent cervical os, using the modified Shirodkar procedure; mercilene tape was inserted instead of fascia lata. In 10 cases, the patient delivered per vaginum after removal of the pursestring, while in 22 delivery was by cesarean section.

4. Diabetic patients who become pregnant should be given expert medical and obstetrical care. It is pretty well accepted today that, after careful study, the pregnancy should be terminated before term, preferably at the 36th or 37th week. The obstetrician must be certain that fetal size permits the interruption; the possibility of a multiple pregnancy with very small fetuses must be considered beforehand. The author[14] has found the method of Reis, De Costa and Allweis extremely satisfactory over many years; confirming fetal size first, terminate the pregnancy at 35 weeks, then handle the infant as a premature baby regardless of its size and birth weight. This eliminates maternal toxemias, keto-acidosis of late pregnancy and the accompanying intrauterine fetal death.

5. Vaginal infections[9, 12] should be discovered promptly, the etiological organism identified, and specific treatment instituted at once. How many times do we discount a patient's complaint of "leukorrhea," saying, "Just a minor complication of pregnancy"?

6. Toxemias of pregnancy jeopardize the life of the mother and reduce the chance of fetal survival. In a severe case of toxemia, the obstetrician often must decide if prematurity is a lesser danger to the fetus than its continued existence in an unfavorable environment.[9] Adequate prenatal care prevents the great majority of severe acute toxemias. Early discovery and prompt treatment of the first signs of an impend-

ing toxemia provide the key to their control and elimination. To protect both mother and fetus, immediate hospitalization and vigorous therapy of severe toxemias is mandatory.

7. Although polyhydramnios may occur infrequently in the first portion of the last trimester of pregnancy, its discomfort to the patient may be quite trying and, in rare instances, its severity may prove incompatible with continuation of the pregnancy. Fish and associates[4] found 11 cases (3.1 per cent) with polyhydramnios among 347 premature deliveries. Only two of the 11 developed premature rupture of the membranes. Rather the association of polyhydramnios with toxemias, fetal deformities and multiple pregnancies would tend to divide its direct contribution towards prematurity. Prevention of polyhydramnios *per se* seems futile; the prevention of toxemias is a primary aim of good obstetric care.

8. In patients with multiple pregnancies, it is important to make the diagnosis early, then provide special care for the duration of their gestations. This includes prevention of toxemias and confinement of the patient to bed, if premature labor threatens.[12, 14] Selected drugs mentioned below, may be of value, if they are administered promptly.

9. Hemorrhage during the last trimester usually is treated with maximal safe expectancy,[4] but the major factors in its prevention seem to lie within the premises of adequate prenatal care.

10. Premature rupture of the membranes may be accidental or intentional (see No. 11, below). Multiple pregnancies and fetal deformities contribute to the former, as well as polyhydramnios, and an incompetent cervix. Although these have been discussed, it might be added that accidental maternal trauma occasionally is the sole etiology to be found in connection with premature birth. Prenatal care should outline, among other plans, a program which provides moderate exercise for the patient, excluding potentially hazardous activities such as horse-back riding, skating and tedious, long automobile trips.

11. To avoid the majority of hazards associated with prematurity following an elective induction of labor, the obstetrician must (a) be reasonably certain of the weight and maturity of the fetus and (b) balance the hazards of immediate delivery against the indication he chooses for the induction. He must carefully evaluate the length of gestation by the "clinical size" of the fetal ovoid and an x-ray appraisal of fetal size and maturity indicated by visualization of the proximal tibial and distal femoral epiphyses. It would appear that the risk of fetal damage from minimal exposure to x-ray would be far less than the hazards of fetal mortality due to ineptly timed repeat cesarean section.[6] Repeated exposure to x-ray is not recommended.

Concerning inductions "for convenience," the burden of responsibility for obtaining a good, mature baby lies heavily upon the obstetrician; in a question of prematurity (all factors being equal), he will do well to remember that the unborn fetus gains in weight about 10 oz. per week during the last four weeks of gestation. He may choose to "wait another week." If he finds it necessary to stimulate labor using oxytocic drugs, the patient should be under continuous observation; the fetal heart rate should be recorded frequently.

12. Exactly the same precautions (see No. 11 above) hold for (elective) repeat cesarean section.[6] With the present pregnancy uncomplicated, usually the patient who has had a previous cesarean operation can be allowed to approach term before the second section is performed. Misjudgment of the patient's due date[4] can be avoided by a careful evaluation of the size and maturity of the fetus before operation. Some authors choose to allow the selected patient with a previous section to go into labor,[9] and they may even consider a vaginal delivery instead of the repeat section; others consider this practice obsolete and dangerous, but it usually avoids prematurity. The stomach of the newborn should be emptied by aspiration immediately after cesarean delivery.

13. Prevention of fetal causes enumerated above can be more easily grouped for discussion under management of the patient after the onset of premature labor, to effect fetal salvage.

### Fetal Salvage

All efforts to prevent premature labor having failed, the obstetrician is confronted with a more perplexing problem, e. g., how to salvage the premature fetus. Principally, this question involves how he shall prevent fetal anoxia, birth injuries, infection and abnormal pulmonary ventilation. Proper management of the patient in premature labor will salvage a fetus in from 20 per cent to 35 per cent or more of cases.[2, 16]

1. Arrest labor. With the membranes intact and a minimum of bleeding present, an attempt should be made to forestall labor. Although no single remedy may be found sufficient for this mighty challenge, a number of useful agents have been reported. Bed rest seems to be imperative at the onset of labor although hospitalization may or may not be required.

(a) Majewski and Jennings[10] reported favorable results in 80 per cent of 21 cases with the pa-

tient receiving Lutrexin (uterine relaxing factor, H. W. D.) in periodic doses until contractions ceased.

(b) McCarthy[11] employed Releasin (a purified preparation of Relaxin, W. C.) in 15 cases with a similar number of controls; favorable results were reported in 12 cases.

(c) Stephens[15] reported 76 patients with 81 pregnancies, all candidates for premature labor over a nine-year period of time. He prescribed Dactil (N-ethyl-3-piperidyl diphenylacetate hydrochloride-Lakeside) 50 to 100 mg. by mouth four times a day until delivery, or to the 39th week of gestation; results were successful in general, with no adverse effects. Stephens declares that the babies weighed a pound more due to prolongation of pregnancy. For more obstinate cases he also used Dibuline sulfate (M. S. D.) 25 to 50 mg. hypodermically, but noted occasional side-effects. The drug is limited to hospital use, according to his report.

(d) Estrogens have been tried in the past. Bruns and co-workers[3] studied 58 women to correlate urinary steroid metabolites with uterine mobility in normal and abnormal pregnancies. They noted a reduced uterine circulation in patients who delivered prematurely, regardless of estrogen therapy. Natural estrogens given over a two-week period did not suppress excessive uterine contractility. Likewise, progesterone was found to be ineffectual.[9]

2. During premature labor, management of hemorrhage must be directed towards conservation of blood loss, and prompt delivery with maximal safety both for the fetus and the mother.[4] Every case must be treated on the basis of its own pathology.

3. Hypnotic, narcotic, analgesic and amnesic drugs should be omitted during labor; if administered at all, they should be given early in labor and the dose should be minimal. This precaution aids in preventing fetal anoxia and abnormal pulmonary ventilation.

4. General anesthesia should be replaced by regional anesthesia such as caudal, saddle-block, or pudendal block, for delivery. Extra caution during the administration of caudal or saddle type anesthesia will avoid transient arterial hypotension which often produces a fatal hypoxia in the little fetus, or permanent cerebral damage due to primary anoxia.

5. A spontaneous (atraumatic) delivery with an episiotomy is believed to be ideal for the premature fetus. Forceps should be employed when the second stage of labor is prolonged. Conversely, a precipitous labor and delivery produce intracranial damage in the small fetus; "a few whiffs of ether" administered by the open drop method is thought to be less damaging to the fetus than a rapid, tumultuous delivery.[9]

6. Oxygen should be administered to the mother several minutes before delivery (very little after the first 10 seconds). If the infant is placed across the mother's abdomen after delivery, the umbilical cord should be clamped at once. Stripping or "milking" the cord towards the baby before clamping it increases its blood volume, but may prove dangerous if there are anomalies of the cardiovascular system or intracranial hemorrhage, or if a maternal-fetal blood group incompatibility is present.[12]

7. Airways of the premature infant should be cleared at once by gentle aspiration; the baby must be kept warm, and should receive expert premature care from a qualified physician without delay. Resuscitation is employed if indicated, but should be administered by an experienced individual to avoid fetal trauma. The immediate need for special care of the premature infant is clearly indicated in the use of the Apgar ratings.

8. Breech presentation should be diagnosed early in labor, if possible. Complications can then be anticipated before delivery, e. g., incarceration of the aftercoming head in the poorly dilated cervix or prolapse of the umbilical cord.[14]

9. Toxemias, believed to be chiefly preventable, usually prove hazardous for the premature fetus, as well as for the mother. Supportive therapy includes (a) elimination of the sodium ion, (b) relief of the vasospasm (hypertension), (c) removal of the cause (the fetus) and (d) control of the convulsions, in eclampsia. The parenteral administration of hypertonic glucose and magnesium sulfate is a fundamental in therapy. Veratrum viride derivatives have found favor in the treatment of toxemias during the past decade; Unitensen (I. N.) and Apresoline (Ciba) in combination, administered as a controlled continuous intravenous drip have proven very satisfactory in our hands. Beside general uninterrupted observations, the blood pressure must be carefully charted every three to five minutes while the infusion operates. If the systolic blood pressure falls below 140 mm. of mercury, fetal hypoxia and brain damage may ensue or the fetus may die before delivery. The same precaution should prevail when continuous caudal anesthesia is employed, to prevent convulsions.

10. Concepts concerning the early induction of labor in selected pregnant Rh-negative women have undergone tedious controversy during the past five years. The predominant current trend,

however, still seems to be towards carrying the fetus as close to term as possible.[14] Today all of our mothers carry a card with their blood type and Rh factor clearly established early in the pregnancy. Antibody titres are checked at the end of the 7th month. Upon admission to the hospital in labor an Rh-negative tag is placed conspicuously upon her chart, and samples of cord blood are drawn at delivery for Coombs test, and serum bilirubin if Coombs is positive. If results of the tests, within the hour, indicate sensitization, the newborn is transferred immediately to Children's Hospital for further tests and exchange transfusion, if indicated. The same program holds for the fetus with potential ABO blood incompatability, except that the serum bilirubin determination is far more helpful than the Coombs test. We have salvaged many a fetus through this routine and feel that until more mysteries are solved and a direct treatment is available for these dyscrasias, it is worth while to continue along this course of action.

### Recommendations

In order to further reduce the number of premature births, and fetal deaths among prematurely born infants, we must embark on a gigantic program of education for physicians and the lay public. The program should be operated by a team consisting of physicians, nurses, social workers and other selected lay persons, each member to contribute an important share to the project. Research into the causes and prevention of prematurity should be continued with added vigor. Results of observations should be thoroughly coordinated between all categories of physicians and personnel dealing with the premature infant, to train them in proper management of the small fetus, and to avoid reduplication of effort. The following specific points should be introduced into such a program:

1. A systematic perinatal mortality study should be conducted on a monthly basis[1] in every hospital operating a maternity service. The writer[14] was privileged to participate in the planning and inauguration of the Franklin County (Columbus) Perinatal Mortality Study three years ago. Monthly meetings are held in each hospital having a maternity service; every perinatal death is presented anonymously, discussed, and then it is voted upon as to avoidability and responsibility. The project has stimulated tremendous interest in perinatal deaths and their prevention. Results obtained so far indicate that it will be equally as successful as the Franklin County Maternal Mortality Study, which is now in its 12th year of operation.

Very recently a perinatal mortality study has been organized covering the state of Ohio.[1] This project is tremendous in scope, but it is felt that its educational impact will far exceed the huge effort required for its organization and maintenance.

2. Preconceptional and prenatal care must be improved; the patient must be educated to register with her physician early in the pregnancy. This is particularly important for the patient who has had premature labor with a previous gestation. But the program of adequate prenatal care is primarily the responsibility of the physician. What is "adequate care?" In 1957, the Committee on Maternal Health of the Ohio State Medical Association, after three years of research, published a document titled "Guiding Principles for Obstetric Care." This simple but all-inclusive brochure covers minimum standards for all phases of care to be provided for the maternity patient; we use it in connection with the Ohio Maternal Mortality Study.

More recently (March 1959), a "Manual of Standards in Obstetric-Gynecologic Practice" was published by the American College of Obstetricians and Gynecologists. You are cordially invited to peruse this excellent pamphlet. Prenatal care and all other phases of obstetric supervision in their highest connotations are carefully outlined as a guide for the practitioner. Along the same line, there should be a better continuity between out-patient and in-patient care of the pregnant woman.

3. Physicians should survey medication and anesthetic agents now employed during premature labor and delivery, with a view to diminishing the amount used, or to selecting an agent which will have no adverse effects upon the small fetus. The height of a safety factor is measured by the skill of the person administering the anesthetic. Anesthesiology departments in hospitals should be re-evaluated with the idea of improving their services to maternity patients.

4. Resuscitation of the newborn infant, with its modern concepts, should be taught to all physicians and nurses serving patients in the delivery room and the newborn nursery. A splendid pamphlet titled "Resuscitation of the Newborn Infant" is available without charge from the American Academy of Pediatrics, Evanston, Illinois. This brochure provides an excellent nucleus for a training schedule.

5. Efforts should be made through the educational program encouraging physicians to maintain good records and inscribe accurate diagnoses on the standard certificate of death and stillbirth. This applies particularly to birth injuries, mal-

formations and contributing maternal causes. The generally poor quality of data on certificates and records is decried by many authors[4, 9, 12, 17] as a primary detriment to progress in research concerning premature birth.

6. More autopsies performed for further pathological examination of premature infants will increase the available knowledge concerning an accurate cause of death. Autopsies should be encouraged at all levels. Considering that no etiology for premature labor and delivery can be found in from 30.7 per cent to 64.7 per cent of cases,[12] we must gather more reliable information for future research. Pathological studies must be completed in all cases, if possible.

7. Special attention should be directed towards general care of pregnant women among immigrants or underprivileged groups in larger cities.[2]

8. "Premature centers" should be established in localities where the birth rate warrants them. These centers should provide complete facilities for the care of the premature infant. In localities where these centers are not feasible, every attempt should be made to improve the total care available for the pregnant woman and her premature infant. Adequate consultation should be available for all patients with complications of pregnancy and labor and who proceed to premature delivery.

As a closing thought, it seems suitable to quote the observation made by Dr. Edith Potter: ". . . the greatest benefit from any study is derived by the people most intimately concerned with it . . . It is much more valuable for us to discover our own weaknesses than to have others point them out."

### Summary

1. The incidence, etiology, prevention and management of premature birth are presented along with a brief review of the literature.

2. Prematurity appears to be accompanied most frequently by obstetrical complications or maternal pathology; hence, its further reduced incidence depends upon research directed towards removal of maternal factors.

3. Recommendations are presented for an extensive program to aid in such removal.

4. Initiation and maintenance of a systematic study of perinatal deaths play important educational roles in the total effort.

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*. . . no person who is enthusiastic about his work has anything to fear from life.*

SAMUEL GOLDWYN.

# Adrenal Cyst

## (Case Report)

*C. B. Pride, M. D.*

Adrenal cysts are remarkable because of their rarity as well as the problems inherent in diagnosis. Adderley and associates,[1] in 1955, listed the number of reported cases at 81. The majority of these were noted at autopsy, while the rest were observed during operative procedures. The authors concluded that the only adrenal cysts of clinical importance are the lymphatic and the hemorrhagic, that their effects are the result of pressure on adjacent structures, and that they do not produce symptoms of endocrine disturbance. Abeshouse and associates,[2] in 1959, collected from the literature and reviewed 155 cases, 64 of which were operative, the others seen at autopsy. Approximately one-half of the surgical cases were pseudocysts (hemorrhagic extravasation within or around a normal or pathological adrenal gland) and one-third were endothelial cysts (lymphatic or serous). In a few instances, concomitant pheochromocytoma, Cushing's syndrome, or malignant tumor was observed. Included in the study of 155 cases were 12 reported by Ellis and others,[3] in 1952. Four of these were serous cysts; three resulted from hemorrhagic necrosis in adrenal tumors (pheochromocytomas, one functional); five were caused by resolution of hematomas.

Almost all reported adrenal cysts have been benign. The effects of such tumors are mechanical and the symptoms vary according to the structures pressed upon by the enlarging mass. Most of the patients who are operated on have clinical features of palpable abdominal growth in the involved side, dull pain in the region of the adrenal, and mild gastrointestinal disorder.

The correct diagnosis seldom is made preoperatively. The adrenal relation of the cyst can be determined only at operation and its nature defined by pathologic examination. Sometimes exact diagnosis is not possible even postoperatively, especially in cases in which the cysts have attained large size, because pathologic indicants have been obliterated as a result of distention and distortion from pressure of the contents. A few instances have been reported in which the correct preoperative diagnosis was presumed on the basis of a mass localized in the adrenal region, the periphery of which was outlined by a thin, laminar calcification of the cyst wall.[4] X-ray examination such as pyelograms, gastrointestinal series, barium enema, and others, are important in detection and localization of adrenal cyst. Listed among the possible causes are trauma, congenital anomaly, and acquired defect, aneurysm of any type and lymphangiectasia, the incomplete linkage of minute lymph spaces with the larger lymphatic vessels.

Submitted to the Publication Committee, May 12, 1960.

### *The Author*

- **C. B. Pride, M. D., Clinical Professor of Surgery, West Virginia University School of Medicine, Morgantown, W. Va.**

### Case Report

A 51-year-old woman was brought to the hospital on January 27, 1955. Forty-eight hours earlier she had had mild intermittent attacks of epigastric pain which had subsided somewhat until a few hours before admission, when she experienced severe chest pain and abdominal pain, with vomiting. Her blood pressure was 192/90, temperature 98, pulse 78, respiration 26, weight 185 pounds (83.9 Kg.), height 5 feet, 7 inches. Demerol was given and within a short time the acute distress abated and the blood pressure returned to within normal limits.

The patient's previous illnesses included a gangrenous appendix which was removed through a McBurney's incision in 1937. From about 1946 until two months before admission, the patient had had frequent episodes of severe headache, weakness, short periods of unconsciousness, hot flashes and what she described as severe asthmatic attacks. Despite these episodes she continued to gain weight and was not incapacitated for more than a few days at any one time. On one occasion at the age of 44 (1948), she collapsed after an intense headache. The "blackout," which was her most severe one, lasted about 30 minutes. After regaining consciousness she was extremely nervous and apprehensive. At that time her menstrual periods were occurring every

two weeks. The duration of each period was approximately sexen days and the flow was profuse. She did not remember how long this disorder had lasted, but stated that she had been treated for menopausal disturbance by her family physician. At the time of admission her periods had been normal, except for scant flow, for a number of years.

Since the physical examination showed no abnormalities excepting generalized soreness of the abdomen, appendectomy scar and obesity, x-ray studies of the chest, gallbladder, stomach and kidneys were made. The roentgenograms showed a tumor (Figure 1) which measured 4 inches in diameter, in the right upper and central portion of the posterior abdominal cavity. In the retrograde pyelogram (Figure 2) the mass was in close proximity to the upper pole of the right kidney which was displaced downward and rotated outward. The roentgenologic diagnoses included the possibility of tumor of the kidney, tumor of the adrenal, or retroperitoneal nonspecific tumor.

Other studies and examinations, including urine and blood tests, were within normal limits. No abdominal tumor was palpable.

During the tests the patient was comfortable and asymptomatic until 10 days after admission, when the attacks of severe abdominal cramps and vomiting recurred. At this time, a tender, irreducible, walnut-sized lump was palpated in the midline, 1 inch below the umbilicus; had it been above the umbilicus, the diagnosis of epigastric hernia would have been made. It is possible that the lump was an incarcerated hernia when the patient first entered the hospital, and was overlooked as occasionally happens, especially in the obese patient. She stated that for a number of years a small lump had been present below the umbilicus but because it caused no pain she had not been concerned.

Both lesions were explained to the patient and an operative procedure for correction of the hernia, also exploration and possible removal of the cystic mass in the right upper portion of the abdominal cavity was advised.

The midline hernia was investigated and the only contents of the small sac were omentum and sanguineous fluid. It had no connection with the McBurney scar nor the umbilicus. The gangrenous portion of omentum and the sac were excised.

The incision was then enlarged to permit manual examination of the abdominal cavity. No tumor comparable to the one seen on the x-ray films could be palpated, although one or two soft, lobulated masses were felt on the posterior wall near the midline. Even if the growth had been palpated by further upward enlargement of the incision it is doubtful that

Figure 1

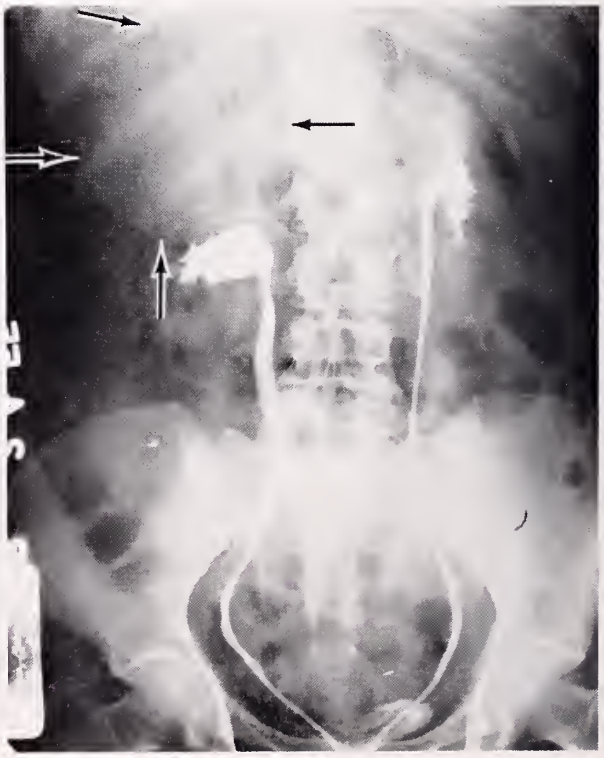

Figure 2

removal could have been accomplished through an abdominal approach.

The patient's postoperative course was uneventful and she was discharged, with instructions regarding the importance of future examinations.

Nothing was heard from the patient until July 7, 1957, two and one-half years later, when she was readmitted to the hospital. Two months earlier she had noticed a blood-tinged vaginal discharge which lasted three days, also progressive abdominal enlargement, with discomfort which consisted chiefly of "burning" in the right side of the abdomen. Because of worry about cancer and abdominal discomfort, her consumption of food had decreased greatly and she had lost 15 pounds. There had been no recurrence of abdominal cramps nor of vomiting since repair of the incarcerated ventral hernia in 1955.

On the second admission the patient did not appear ill. There was no jaundice. Blood pressure was 170/80, weight 170 pounds (77.1 Kg.). Menstrual periods had ceased in 1956. Pelvic examination and other examinations showed no abnormality except for a palpable, globular, fixed, slightly elastic, nontender tumor in the right side of the abdominal cavity. The mass extended from the ribs to below the umbilicus and to the left of the midline. A roentgenogram of the abdomen showed a growth (Figure 3) measuring 8 inches in diameter, about twice the dimension of the original tumor observed two and one-half years before. On the basis of present physical evidence, the past history, and knowledge gained from the x-ray studies as well as from the exploratory procedure in 1955, the diagnosis of retroperitoneal tumor, probably cystic, was made, and the patient underwent operation July 12, 1957.

Through a long right rectus incision, the underlying structures were divided and a rounded, dark, beef-like, cystic tumor, approximately 8 inches in diameter, was disclosed. Grossly it resembled a large hematoma or a strangulated lipoma. After removing a thin layer of hemorrhagic, adherent omentum and incising the membranous covering which probably was the posterior parietal peritoneum, the cyst was freed from the surrounding structures by blunt dissection. Near the end of the operation a thin area of the cyst wall was accidentally opened and a large amount of chocolate-like blood and at least one pint of serosanguineous fluid escaped. This reduced the size by about one-third and the rest of the dissection was easily carried out, with minimal bleeding.

There was no pedicle nor apparent connection with any adult anatomical structure, and no portion of the intestine was immediately adherent to the cyst wall. Only one small blood vessel was ligated and that was at the sessile base near the root of the mesentery. The attachment in this region, however, seemed little more than the attachments elsewhere. Whether or not the blood vessel was thrombosed could not be determined because it was ligated before division. There was no free blood or fluid present in the abdominal cavity. The right kidney and the gallbladder were normal. After the tumor was removed the anterior surface of the kidney region was devoid of posterior peritoneum. The patient made a satisfactory recovery.

The pathologist's observations[7] of the gross appearance of the specimen were similar to those noted by the surgeon. The report of microscopic examination included the following data:

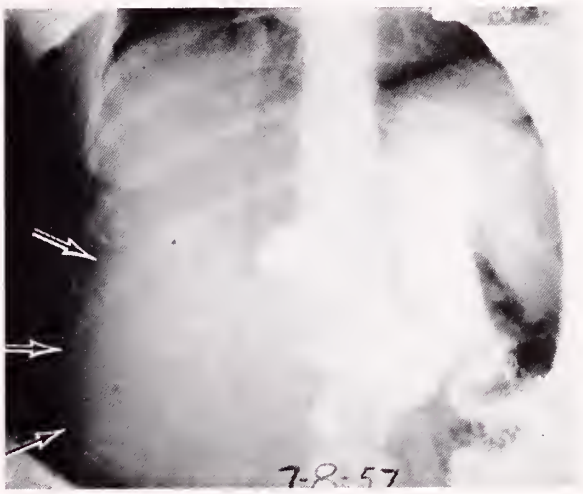


Figure 3

"Blocks were cut through the periphery of the mass to include both the outermost portion of the membrane and the central granular brown material. Sections of all blocks were similar in that four more or less distinct zones were included. The outermost zone consisted of compact but cellular fibrous connective tissue composed of parallel layers in the form of a capsule. Scattered throughout this most superficial or capsular portion of the mass were one-cell thick columns and sheets of cells judged to be epithelial. The cells were polyhedral, cuboidal, or columnar and had an abundant amount of finely vacuolated cytoplasm. The nuclei were centrally placed, round and characteristically hyperchromatic. These cells were for the most part entirely surrounded by fibrous connective tissue. In some instances the cells lay immediately beneath and in contact with the endothelial

lining of thin-walled blood vessels. Sudan III preparations disclosed these cells to contain a finely dispersed sudanophilic material. A silver carbonate preparation controlled against an appendiceal carcinoid was negative for argentophilic granules. Sections of chromated material disclosed no chromaffin pigment.

"The next deeper zone was also of connective tissue and was extensively hyalinized and in places calcified. Between this layer of scar tissue and the coagulum of denatured blood which constituted the main central portion of the mass there was a layer of richly vascularized granulation tissue of the type commonly seen at the margin of an organizing hematoma. The giant capillaries encountered in some parts of this granulation tissue resembled those of an organizing subdural hematoma. The fourth and innermost zone which comprised most of the mass was a mixture of formless proteinaceous debris and more recently extravasated blood.

"Diagnosis: Recent and remote hemorrhage into adrenal with formation of massive intra-adrenal hematoma."

"Note: This is certainly a cystic hematoma. The original hemorrhage occurred many weeks, months, or years ago. There have been repeated subsequent episodes of bleeding some of which have been very recent. The most recent hemorrhage probably occurred from the capillaries of the granulation tissue. The cause of the original hemorrhage is not disclosed. It may have been traumatic. Although I believe that the columns of epithelial cells in the capsule represent the atrophic remains of the adrenal cortex, I cannot prove that this is the case."

### Comment

In the case reported, the patient gave no history of any specific trauma. Of particular interest were the symptoms of severe headache, blackouts, and asthmatic attacks over a period of seven or eight years before the first admission. Whether these resulted from pressure on such important structures as the cociliac plexus and the diaphragm by the enlarging cyst under the diaphragm and behind the liver, from endocrine disturbance in which the adrenal medulla was involved (pheochromocytoma, functional) and then later destroyed by hemorrhagic extravasation, from a combination of these, or from other cause only can be guessed.

With two exceptions the blood pressure readings during both hospital confinements were normal or below normal. Also of interest was the coexisting midline hernia which created additional problems in the surgical treatment and caused the severe intermittent abdominal cramps.

Immediately after removal of the cystic mass and before the exact diagnosis was made by the pathologist several months later, the diagnosis of primary retroperitoneal cyst was considered as a possibility because the tumor had no apparent connection with any adult structure, was not on a pedicle, and was easily removed. In reviewing several individual case reports of primary retroperitoneal cysts, which usually were lymphatic, two cases of special interest were found. One was reported by Roller,[5] the other by Lee.[6] Both patients were between the ages of 50 and 60 and both had epigastric hernia. At operation each hernial sac contained chyle. From two to three years later large retroperitoneal cysts with chyle as the content had developed in both patients. Since nonincisional hernia in the midline or in the semilunar line usually is acquired, it is possible that such a process might occur along the posterior abdominal wall. The strangulation of a small lipoma or the trapping of blood or lymph could result in cyst-like formation, and if the extension was downward into the abdominal cavity there would be little pain because no important nerves would be pressed upon.

### Summary

A case of benign pseudocyst of the adrenal with a concurrent linea alba hernia is described, with speculation as to possible causes. The patient made a satisfactory recovery as would be expected. She has had no recurrence of the preoperative symptoms. When last examined in 1960, three years after the operation, she was in excellent health; her only complaint was obesity. She weighed 203 pounds (92.2 Kg.).

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# Carcinoma of the Cervix*†

*Neopito L. Robles, M. D., and Karl J. Myers, M. D.*

Carcinoma of the cervix is perhaps the most important cancer to which the female is subject, because it can be diagnosed in the pre-invasive stage by cytologic methods and can be cured in almost all cases if treatment is instituted early. The disease causes the death of approximately 35,000 women in the United States every year and in the female sex is second only to carcinoma of the breast.[1] It is the most easily cured of all malignant lesions, with the exception of carcinoma of the skin.[2]

The present 5-year salvage rate, for all stages, is around 41.5 per cent.[3] The medical profession is faced with the herculean task of raising this low per cent of survivals. The patient who does not consult a physician immediately upon discovery of abnormal vaginal bleeding and the physician who does not perform an adequate examination are the two greatest stumbling blocks to this goal.

Almost all patients with carcinoma of the cervix give a history of abnormal vaginal bleeding. The early signs are post-coital bleeding, post-menopausal bleeding, or menometrorrhagia, in contrast to the late symptoms which are pain, pressure in the bladder region or rectum, loss of weight, weakness, and exsanguinating hemorrhage. A pelvic examination under optimal conditions is essential for making a definite diagnosis. Suspicious areas in the form of small erosions or ulcers should be biopsied and an histological study made. Cytological examination usually is reserved for screening purposes.

The importance of developing public and professional awareness of the disease cannot be overemphasized. Only by proper diagnostic procedures, done early, and followed by intensive treatment, when indicated, can the current low survival rate be raised appreciably.

For the purpose of reporting and comparing cases of carcinoma of the cervix, the extent of the disease must be accurately described. It is only when this is done that the results of treatments used for this disease can be properly evaluated.


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The League of Nations classification is perhaps the most widely known. It recently has been modified to include carcinoma in situ and is now known as the International Classification for Carcinoma of the Cervix Uteri.[4]

Stage O
Carcinoma in situ, also known as pre-invasive carcinoma or intra-epithelial carcinoma.

Stage I
Carcinoma confined to the cervix.

Stage II
Carcinoma extending beyond the cervix, but not reaching the pelvic wall; involving the vagina, but not the lower third.

Stage III
Carcinoma reaching the pelvic wall; on rectal examination, no cancer-free space found between the tumor and the pelvic wall.

Stage IV
Carcinoma involving the bladder or rectum, or both, or extending beyond the limits previously described.

As a result of the revival of radical hysterectomy for carcinoma of the cervix and the addition of exenteration of the pelvic organs, Meigs and Brunschwig proposed a new classification for the disease, based on the extent of the tumor found in the surgically excised tissues.

Histologically, about 95 per cent of cases of carcinoma of the cervix are of the squamous cell variety and approximately 5 per cent are adenocarcinomas.

Surgical treatment for carcinoma of the cervix was revived about 15 years ago. This was made possible because of improvement in anesthesia, better preoperative and postoperative care, better understanding of fluid and electrolyte balance, the use of antibiotics, and the ready availability of blood. These improvements have made prolonged and radical operative procedures in the pelvis relatively safe, the mortality rate being

*Presented by Doctor Robles before the annual meeting of the West Virginia Chapter, American College of Surgeons, at The Greenbrier in White Sulphur Springs, April 1-2, 1960. This paper was judged second best among those presented by residents from hospitals throughout the state.

†From the Tumor Clinic, Broaddus Hospital, Philippi, W. Va. Submitted to the Publication Committee, April 18, 1960.

around 5 to 10 per cent. The different methods of surgical intervention currently in use are (a) radical hysterectomy, (b) anterior exenteration, (c) posterior exenteration and (d) total exenteration. The operations are fully described in several excellent articles in the current medical journals.[5, 6, 7, 8] They should be done by surgeons trained to do such procedures and in situations where a well trained, well coordinated team and a laboratory equipped to supply large amount of blood in a short time are available.

The use of irradiation for carcinoma of the cervix consists of localized radium treatment and external irradiation. This form of therapy is more widely used throughout the world than radical surgery. It can be given in a number of different ways and with varied technique. The proper dose of radium and external irradiation for each particular case can best be determined and applied by close cooperation between the radiotherapist and the clinician.

In our institution, treatment is individualized and always a combined undertaking. We formerly started treatment with external irradiation using a 250 P.K.V. x-ray machine. In 1954 Cobalt 60-teletherapy replaced x-ray for this purpose. Treatment to the pelvic region is given through eight portals: (1) anterior left and right, (2) posterior left and right, (3) lateral left and right and (4) bi-ischial portals. In the series we attempt to deliver 4,000 to 5,000 tissue roentgens to the cervix, paracervical areas and pelvic nodes. Treatment is given in small daily doses over a period of 6 to 7 weeks until the course is completed. In certain cases it must be limited or temporarily stopped because of complications such as excessive vomiting or diarrhea.

After 3 to 4 weeks the radium treatments are started. Formerly, we used a tandem tube with a colpostat, according to the Regaud technique, but since 1955 we have been using an Ernst applicator. This is followed by interstitial application of radium needles containing 10 mg. of radium with 0.5 mm. platinum filtration. The needles are placed 1.0 cm. apart and left in place for 10 hours. The total dose of radium in the individual case depends upon the extent and size of the lesion. We usually plan to give around 5,500 to 6,000 mg. hours. The patients are then given follow-up examinations periodically in our tumor clinic. In some institutions, a transvaginal cone is used to give local irradiation in place of the radium. Radioactive cobalt needles also may be used in place of radium. We have had no experience with either technique.

The cases of cervical carcinoma seen at the Myers Clinic and Broaddus Hospital from 1939 to 1953 were analyzed for this report. Of the total number of 122 cases, there were 104 in which treatment was by irradiation. In 18 cases, the treatment was limited to supportive medical therapy because of the extensiveness of the disease and the poor general condition of the patient. In 17 cases, the disease was far advanced and the patients were given palliative irradiation only. In 11 of these, external irradiation was used for recurrence after treatment elsewhere; in the remaining 6 cases, radium therapy alone was used. Eleven patients were initially treated by us but for various reasons did not complete the treatment. Table I shows the number of patients seen and the form of therapy given:

**TABLE I**

| | |
|---|---|
| Total number of Patients | 122 |
| Complete Therapy (radium and external irradiation) | 76 |
| Partial treatment | 28 |
| No treatment | 18 |

Table II gives an analysis of the cases in which treatment was by irradiation during the period referred to.

**TABLE II**

**FIVE YEAR SURVIVAL AFTER TREATMENT BY IRRADIATION**

| | | |
|---|---|---|
| Stage I | 81% | (13 out of 16) |
| Stage II | 66% | (10 out of 15) |
| Stage III | 28% | (12 out of 42) |
| Stage IV | 0% | ( 0 out of 3) |

There were 3 cases with a diagnosis of carcinoma in situ; in one of these, the patient has lived 7 years and shows no evidence of disease; one patient was lost to follow-up, after 3 years without evidence of disease; one died of meningitis after 3 years. This particular patient had been examined in our tumor clinic 3 months prior to her death and at that time there had been no evidence of disease of the cervix.

Sixteen Stage I cases were treated by irradiation and of this number, there were 13 with no evidence of the disease five years later.

Fifteen patients with Stage II carcinoma were treated with irradiation; 10 survived for 5 years after treatment, with no recurrence.

Forty-two patients with Stage III were treated with irradiation; 12 of these are living 5 years after therapy and show no evidence of disease.

Three patients with Stage IV were treated with irradiation and lived 4 years, 1 year, and 6 months, respectively, death in each case being due to the complications of the disease.

There were 7 patients with carcinoma of the cervical stump; 5 of these were clinically Stage I. Only two of the five were free of disease 5 years after treatment.

Two of the 7 patients were Stage III. One survived 9 months, the other two years after treatment. These last figures show that carcinoma developing in a cervical stump frequently does not respond favorably to adequate irradiation, even in the early stages of the disease.

In a certain number of cases, one or more complications developed, requiring hospitalization of the patient. The most common of these were nausea, vomiting and diarrhea. Five patients had severe radiation dermatitis, two had pathological fracture of the femur, two had hemorrhagic cystitis, and six had hemorrhagic proctitis. One patient, while receiving external irradiation, had severe nausea, vomiting and diarrhea. She was hospitalized and died several days later. Post mortem examination showed necrotizing ileitis with perforation and peritonitis. All of these patients had to be admitted to the hospital and given supportive therapy, with recovery in each case except that of the patient with necrotizing ileitis, which resulted in death. A number of the patients became nauseated while receiving external irradiation but responded to medical therapy without being hospitalized. Two years ago we adopted a routine of giving one of the phenothiazines (Compazine Spansules,® 15 mg.) 30 minutes before each treatment. This has markedly reduced the incidence of nausea and vomiting which almost invariably follow irradiation. Table III shows the various complications which required hospitalization of the patient.

**TABLE III**

| | | |
|---|---|---|
| A. | Diarrhea | 13 |
| B. | Nausea and vomiting | 6 |
| C. | Hemorrhagic proctitis | 6 |
| D. | Dermatitis | 5 |
| E. | Rectovaginal fistula | 4 |
| F. | Pathological fracture | 2 |
| G. | Hemorrhagic cystitis | 2 |
| H. | Necrotizing ileitis | 1 |

In 4 cases, rectovaginal fistula developed. In one of these, the patient had undergone supracervical hysterectomy elsewhere; she had external irradiation following the hysterectomy and then was referred to us for radium therapy. Two cases were Stage IV and fistula subsequently developed. One patient with Stage I when treatment was given, returned 7 years later with a rectovaginal fistula and evidence of local recurrence. All 4 of these patients were treated with irradiation.

### Summary

Carcinoma of the cervix with regard to diagnosis, treatment and results of irradiation therapy in 104 cases is discussed. In the Stage I cases, the five-year survival rate was 81 per cent. In the Stage II cases, the rate was 66 per cent, and in the Stage III cases, 28 per cent. There were no five-year survivals in the Stage IV cases.

### Conclusions

Analysis of the 104 cases indicates that the earlier the lesion is discovered, the better the prognosis.

For carcinoma developing in the cervical stump, the prognosis is poor.

Treatment in each case of cervical carcinoma should be individualized, with specific regard to the size and extent of the lesion.

### Acknowledgment

The authors take this opportunity to thank Dr. Hu C. Myers, Head of the Department of Surgery, Broaddus Hospital, Philippi, W. Va., for valuable assistance and encouragement in the preparation of this paper.

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*. . . show me a thoroughly satisfied man and I will show you a failure.*

THOMAS A. EDISON.

# Humane Techniques in Electroconvulsive Therapy

*R. W. Hibbard, M. D.*

THE purpose of this paper is to show that the use of certain techniques in electroconvulsive therapy render it not only safer, but lessen the unpleasant and frightening aspects to the patient and are, therefore, more humane. Since its beginning in this country, electroconvulsive therapy has become popular in the treatment of certain types of psychiatric disorders. For years the treatment carried a fairly low mortality rate, but a significantly high rate of physical complications. As its use increased, so did the frightening aspects of the actual treatment experience in the mind of the lay public. The latter was not without foundation. To the patient and even to some psychiatrists, the treatment was indeed a frightening and an emotionally traumatic experience. To the patient, receiving electric current while awake was envisioned as a horrible experience in spite of the physician's repeated assurance that no electric current would be felt. In addition, certain necessary measures in preparing the fully conscious patient for therapy further enhanced the already rapidly mounting anxiety. The insertion of an uncomfortable mouth gag, the application of electrodes to the temples and the forceable restraint by straps or personnel were extremely upsetting. Specially designed arched treatment tables, or sand bags placed under the patient's back, to lessen the chances of compression fracture of the vertebrae may have given the psychiatrist some small feeling of security, but only increased the patient's physical discomfort and anxiety.

As a result of this crude and frightening experience, many patients often refused to return for treatment or, if they did return, frequently terminated it prematurely. Most of them experienced painful uneasiness of mind about undergoing another electroconvulsive treatment.

### A Humane Technique

A technique devised to render electroconvulsive therapy as safe as possible and the entire procedure relatively free of disturbing emotional factors is carried out as follows:

1. The treatment is explained briefly to the patient, and his questions answered in a simple manner. He is assured that he will be unconscious prior to the application of the electric current. He is given sedation in the form of meprobamate or sodium amytal along with atropine one hour prior to treatment. The same sedation can be used both for outpatients and inpatients, but meprobamate is preferred for outpatients.

2. The patient is treated on a regular hospital carriage, treatment table, or regular hospital bed. There is no need to hyperextend the spine. Care is taken to avoid wheeling a recently treated, unconscious patient in front of a conscious patient awaiting treatment.

3. A soft cotton roll is used as a mouth gag, and is inserted just prior to the injection of thiopental sodium. If the patient objects to the mouth gag, it can be inserted while he is unconscious, just before the current is applied. By utilizing thiopental sodium and succinylcholine, there is no difficulty in its insertion as the entire musculoskeletal system is relaxed. With this technique there is no need to remove the patient's dentures if they fit adequately (a request to which many female patients object).

4. The electrodes are not applied until the patient is unconscious. No physical restraint is needed except light holding of the patient's hands during the convulsion, by the nurse or the doctor.

5. A trained anesthetist or an anesthesiologist is employed who utilizes a small (22 gauge) needle to inject 4 to 10 cc. of 2½ per cent thiopental sodium. At this point the personnel try to distract the patient's attention with pleasant conversation so that the discomfort from the vena puncture will be lessened.

6. After the thiopental sodium has been injected, the needle is left in the vein, and the syringe replaced with one containing 10 to 100 mg. of succinylcholine (depending on the patient's needs). The latter is injected rapidly and, 30 seconds after the muscle fasciculations have ceased, the electric current is applied. The

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Submitted to the Publication Committee, May 11, 1960.

result is a very soft convulsion which, at times, is almost imperceptible.

7. Positive pressure oxygen or room air is maintained by the anesthetist until normal respiration has returned. Apnea due to thiopental sodium or succinylcholine is no problem when positive pressure respiration is maintained.

8. When the outpatient recovers consciousness, coffee or fruit juice is given him. He remains in the hospital outpatient department until he is recovered sufficiently to return home. This usually requires approximately one hour. The inpatient receives breakfast immediately upon arousing.

9. Postconvulsion headache is treated by 10 grains of aspirin. Nausea and vomiting (vestibular in origin) are rare but if they do occur, are treated by Merazine 50 mg. intramuscularly or by rectal suppository; if their occurrence is predicted, a 50 mg. tablet of Merazine may be given one hour prior to treatment.

10. All treatments are given in the outpatient department of a general hospital.

By utilizing the knowledge and skill of a trained anesthetist or an anesthesiologist, there is assurance that adequate respiration is maintained. If vomiting should occur while the patient is unconscious, a suction apparatus is always available to handle the complication.

More than 2500 patients have been treated by this method, with no deaths nor physical complications. Patients with poor cardiac status, advanced age, and recent fracture have been treated with ease. Only one case of postconvulsion excitement has been seen, and this was of a brief duration. With this technique, minimal anxiety over taking electroshock therapy is the rule rather than the exception.

The services of an anesthetist increase the cost to the patient by only an approximate 20 per cent. So far, there have been no objections to the increase. Doubtless the patient and his family realize that it provides for a safer and more pleasant treatment.

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# To Encourage Giving

Taxation is ageless, has existed in some guise since man began a tribal or communal life and has almost eventually been so abused by monarchies, councils, socializers, parliaments and our own Congress as to interfere with the welfare of the State. The latter is quite the reverse of the reason given by our tax collectors and tax spenders to justify our currently high, disabling and confiscatory tax structure—namely, it is supposedly for the welfare of the State.

Historically, the excuses given for high taxes and their ultimate effect have always followed a similar pattern, the result being a police state which with us is carried on under the guise of the internal revenue bureau. The next stage inevitably develops into national demoralization as so well illustrated by Gibbon in the Decline and Fall of the Roman Empire.

The names given to some of the dubious projects which governments utilize to gain more power over their subjects (citizens) by more taxation and more spending and increasing national debt, varies with the times.

By and large the government says it is wiser and better able to spend the people's money for their social welfare than are the people themselves. So we now find our Federal Government involving itself more and more, to mention only two, in the fields of education and biologic research, the latter in no way related to epidemic or communicable disease which is the recognized province of the USPHS.

These are disciplines where, as in many others, the Federal politicians have no business, no facility and no competence. But they do offer great opportunities for more spending and, of course, more taxes since each politician has his own bleeding heart project which he must use to insure his reelection.—Northwest Medicine.

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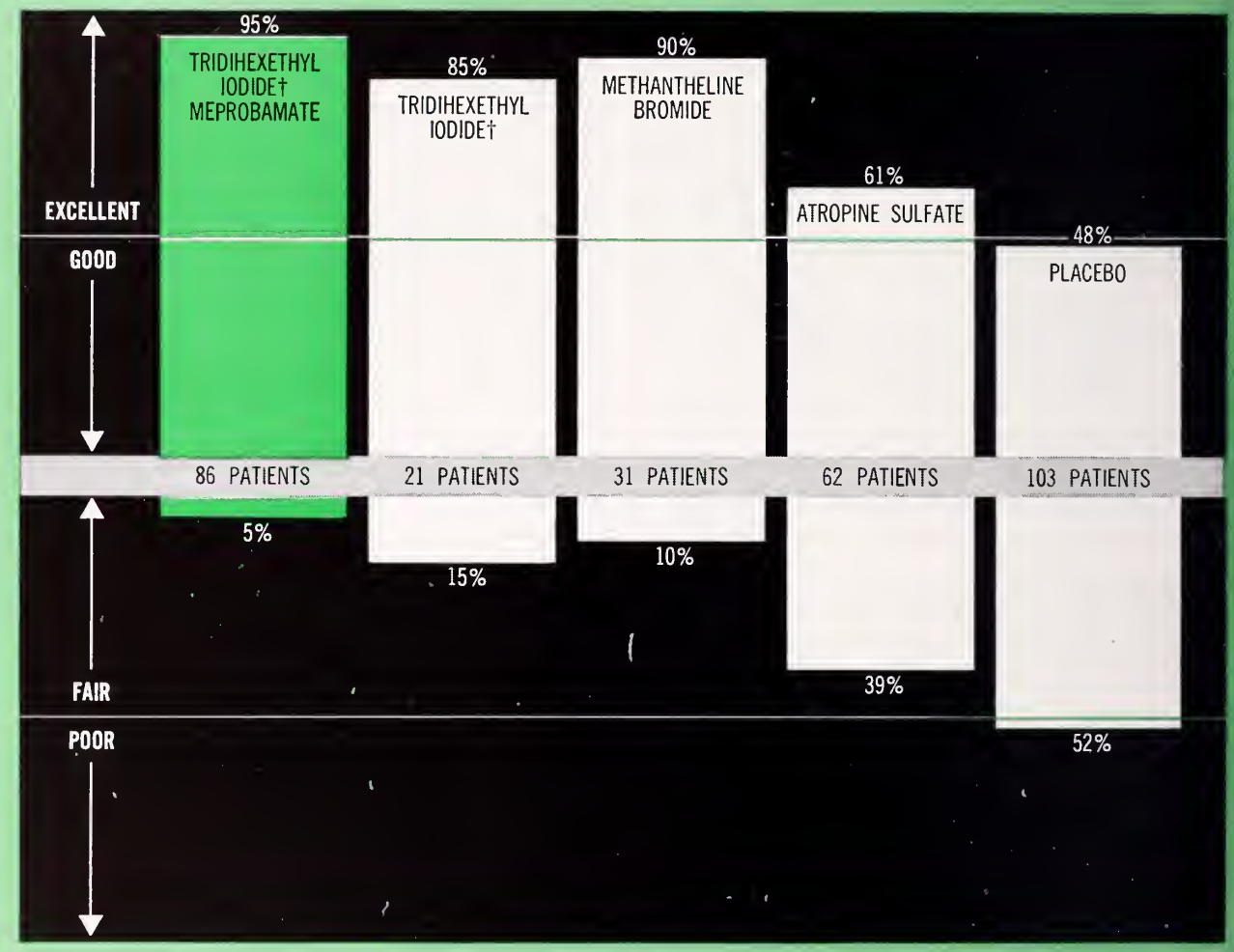


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| VISUAL DISTURBANCES | 0% | 0% | 50% | 34% | 1% |
| URINARY RETENTION | 0% | 0% | 18% | 11% | 1% |
| DROWSINESS | 20% | 0% | 0% | 0% | 0% |
| **COMPLICATIONS OR SURGERY** | | | | | |
| HEMORRHAGE | 0% | 9% | 3% | 9% | 10% |
| PERFORATION | 0% | 0% | 0% | 6% | 0% |
| OPERATION | 0% | 5% | 5% | 14% | 2% |
| **RECURRENCES** | | | | | |
| NONE | 28% | 23% | 25% | 17% | 26% |
| FEWER AND MILDER | 67% | 62% | 52% | 37% | 24% |
| SAME OR MORE | 5% | 15% | 23% | 46% | 50% |

*Atwater, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. Am. J. Digest. Dis. 4:1055 (Dec.) 1959.

†PATHILON is now supplied as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could distort the results of certain thyroid function tests.

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# control the tension — treat the trauma

# Experience in Femoral Prosthesis*

*Luis A. Vazquez, M. D., John O. Rankin, M. D., and Carroll B. Buffington, M. D.*

Although repair of the fractured hip has been a problem of every era in medicine, it was only within the past few decades that constructive repair was devised. The intricate anatomy of the components of the hip articulation and the weight bearing of the neck of the femur prevented previous generations from undertaking the problem of fixation of the fracture in these cases. The devising of anatomical substitutes made of suitable material that would cause little or no foreign body reaction when placed inside of living tissue has contributed greatly to progress in this field.

There are many kinds of femoral prostheses in use today. Our experience has been limited to two principal types, namely, the stem and the intramedullary type. As will be noted from our report, the latter has proved to be the better.


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### Discussion

The following pattern will be observed in discussion:

Preoperative study of the case and decision as to the type of treatment.
Preoperative management of the patient.
Preoperative preparation and operative procedure.
Immediate and further postoperative follow-up.

### Preoperative Study of the Case and Decision As to Type of Treatment

This report covers the following types of cases:

| | | |
|---|---|---|
| a. | Subcapital fracture | 72 |
| b. | Subcapital fracture with nonunion | 9 |
| c. | Other | 1 |
| | Total number of cases | 82 |

*Subcapital Fracture.*—It is a well known fact that regardless of the type of fixation used, there always is a high rate of nonunion. If union does occur, subsequent aseptic necrosis of the head of the femur often takes place. For this reason, we use some type of femoral prosthesis in all cases in which the patient is of the older age group. It is our opinion that the younger patient with a fractured hip should be treated by internal fixation, as in the past. If bony union does not result, a prosthesis can be inserted as a last resort.

The fractured area should be carefully studied by x-ray. Otherwise it might be felt that the hip could be pinned when in reality a prosthesis should be used. Also, it is customary with us to have these patients seen regularly by an internist; he can give us vital assistance in treating them from the medical standpoint and in arriving at a decision regarding the procedure that can be best tolerated.

Decision as to the type of prosthesis is made at the operating table. In the early cases, a number of stem prostheses were used but in the past few years the trend has been toward the intramedullary type.

In the series of 82 cases, 29 stem prostheses of the Judet type were used. It is significant that only five have been used since 1955. During that year two were used, with one each for the years 1956, 1958 and 1959. Two factors favoring the use of the stem prosthesis are that it can be inserted with considerably less difficulty and in a shorter length of time than is the case when the intramedullary type is used. Both elements are of consequence in dealing with a very old or debilitated patient. Stinchfield, Cooperman and Shea[2] obtained good or excellent results in 15 of 23 cases in which a Judet prosthesis was used for osteoarthritis of the hip. Also, they report good or excellent results in 15 of 16 cases in which the same type of prosthesis was used for aseptic necrosis of the head of the femur.

*Subcapital Fracture with Nonunion.*—The patient in the older age group, with an ununited fracture of the neck of the femur, should be treated by the use of a femoral prosthesis. This method was used in 9 of the 82 cases in our series. In each of the 9 cases, the patient had been treated previously, that is, at the time of the fracture, by the use of some type of internal fixation.[3]

*Presented by Doctor Vazquez before the annual meeting of the West Virginia Chapter, American College of Surgeons, at The Greenbrier in White Sulphur Springs, April 1-2, 1960.
Submitted to the Publication Committee, April 18, 1960.

Decision to insert a prosthesis is based on the radiological findings. The patient is extremely grateful once his pain, instability and restriction of movement disappear on replacement of the femoral head with the prosthesis.

*Other.*—In the one case under this heading, that of a patient with Perthes' disease of long standing, the femoral head was replaced with a Lorenzo type of prosthesis. For one year postoperatively, the known result was excellent; unfortunately, the patient moved away from this part of the country at the end of that year and further follow-up was impossible. It has been our experience that the Lorenzo type of prosthesis, because of its mechanical instability, is distinctly unsatisfactory in the vast majority of cases.

**Preoperative Management of the Patient**

First of all, the extent of the patient's injury and the procedure that will be necessary in order to get him back on his feet as soon as possible should be explained to him. We have found that a patient who is mentally alert is only too willing to cooperate, and quite anxious to get on with the operation. In some instances, however, because of his state of mind or perhaps because of the language barrier, such mutual understanding cannot be had with the patient direct, but the entire situation can be explained to the relatives.

In our series of cases, the average age was 73.5 years. Obviously, then, in most of these cases, the patient is not in good physical condition on admission to the hospital and it is for this reason that we are in no hurry to carry out the operative procedure. On our service, it is customary to ask for consultation with an internist with regard both to preoperative and postoperative care. Usually, the patient can be ready for surgery within one week's time. We have found that the use of Buck's extension with 12 or 15 pounds of weight will contribute to the patient's comfort during the waiting period. These patients also are examined thoroughly by a member of the anesthesia department who decides on the anesthetic to be used. We prefer spinal anesthesia because of the relaxed state it affords.

In general, this procedure is well tolerated by the patient when he has been prepared both by the surgeon and the internist working as a team. There have been only two deaths in our series of 82 cases. One occurred 14 days postoperatively, the other at the end of one month.

**Preoperative Preparation and Operative Procedure**

Twenty-four hours prior to surgery the patient is scrubbed from the waist to the ankle with tincture of green soap for a period of ten minutes. The skin then is rinsed with alcohol, after which the area is painted with tincture of merthiolate and wrapped in sterile towels.

It is felt that the choice of incision should be that which the surgeon can use best. Contrary to Moore's[1] "southern approach," we prefer an anterolateral incision, starting it at the anterior superior spine of the ilium and carrying it to the approximate junction of the middle and upper thirds of the thigh, then extending it posteriorly along the crest of the ilium for a distance of 3 to 4 inches.

The gluteal muscles are detached from the ilium subperiosteally down to the acetabulum. The tensor fasciae latae and the vastus externus muscles are retracted laterally. As a rule, the rectus femoris can be retracted medially without severing its attachment to the anterior inferior spine of the ilium. This affords perfect exposure of the articular capsule which is opened through an inverted T incision. The head of the femur usually can be removed in one piece. If this proves difficult there is no objection to removing it piecemeal. We have found that in most cases the ligamentum teres was ruptured at the time of fracture. Should a part of it remain, it is resected at its base in the acetabulum. Troublesome bleeding usually can be controlled by electrocoagulation. Incomplete removal of the ligament may result in some pain postoperatively.

Selection of the prosthesis to be inserted is a significant step in the operation. Care should be taken to see that it complies with the exact measurements of the extracted femoral head. Any ordinary caliper may be used but if none is at hand the two bars of a self-retaining retractor will serve in obtaining the measurements. It is felt that an ill-fitting head may contribute to postoperative pain.

*Insertion of the Prosthesis.*—The leg is flexed at right angles at the knee and placed across the opposite leg, with the hip in external rotation as much as is possible, bringing the open end of the femoral neck into view. If a stem type of prosthesis such as the Judet is to be used, the neck of the femur is squared off with rongeur forceps so that the base of the prosthetic head fits against it firmly. The direction in which the stem should be inserted is determined by the direction of the neck of the femur. The stem must be long enough to perforate the lateral cortex of the shaft of the femur when the head of the prosthesis is driven down snug against the femoral neck.

When using an intramedullary type of prosthesis such as the Austin Moore, it is our custom to rongeur away all of the remaining neck of the femur. This practice usually will serve to pre-

vent splitting of the femur when the prosthesis is driven home. We have found that with the leg in complete external rotation and the head of the prosthesis in internal rotation as much as possible when it is driven into the shaft, the correct angle of the prosthesis in relation to the shaft of the femur will result.

There are two complications, either of which may occur when the intramedullary prosthesis is inserted: (1) the upper end of the shaft of the femur may split if the stem is too large and (2) failure of the stem to follow the course of the medullary canal may result in perforation of the lateral side of the cortex by the stem's tip. The latter complication has occurred twice in our experience but as only a small tip of the stem protruded, there were no ill effects; in both cases the results were classified as excellent.

Introduction of the head of the prosthesis into the acetabulum is a procedure fairly easy of accomplishment. A skid is placed over the prosthetic head and is hooked onto the superior lip of the acetabulum. Using this as a pry, traction is exerted on the leg as it is brought around into internal rotation.

The T incision in the capsule is closed with stainless steel wire. We feel that this will help prevent, subsequently, the complication of anterior dislocation of the head of the prosthesis. This has not occurred in any of our cases but has been reported in the literature. The rest of the operation is confined to closure of the various muscle planes. Postoperatively, the patient is placed in bed with a pillow under the knee to keep the thigh slightly flexed. A sand bag is placed on either side of the leg so that the foot will be maintained on a vertical plane.

#### Immediate and Further Postoperative Follow-Up

The patient in each case is followed both by the internist and the surgeon. Our routine postoperative orders are listed below:

(a) Place leg on one or two pillows.
(b) Apply ice packs to operative area.
(c) Maintain the leg internally rotated with the aid of sand bags.
(d) Analgesic therapy.
(e) Hypnotics.
(f) Anticoagulant therapy (when necessary).
(g) Clear liquid diet for the first 24 hours; bland diet the next 24 hours; regular diet thereafter (as tolerated).

The patient usually is up in a chair the day following operation and is given instructions for quadriceps and foot exercises. Two weeks later he begins full weight bearing on the affected limb, with the aid either of crutches or a walker. After a week or ten days of ambulation in the hospital, the patient usually can be sent home; before he leaves the hospital he is instructed to return in approximately three months for a check x-ray and for evaluation of his condition with regard to progress.

In tabulating results, we find Reynolds'[3] outline of classification to be extremely useful:

a. Excellent—stable, relatively painless, relatively normal range of motion; able to walk without support; good endurance.
b. Good—same as above, but patient uses a cane or a crutch at times.
c. Fair—as above, but patient uses a cane or a crutch most of the time.
d. Poor—considerable pain; not ambulatory.

The results in our series of 82 cases treated during the period 1952 to 1959 are tabulated below.

**TABLE OF RESULTS**

| *Type of Prosthesis* | *Excellent* | *Good* | *Fair* | *Poor* | *Not Rated** | *Deaths*** |
|---|---|---|---|---|---|---|
| Austin Moore | 26 | 5 | 2 | 3 | 12 | 1 |
| Judet | 0 | 6 | 2 | 3 | 17 | 1 |
| Lorenzo | 1 | 0 | 0 | 2 | 1 | 0 |

*Cases resulting in death or cases in which contact with the patient was lost.

**Cases in which death occurred postoperatively in hospital.

In 2 cases, infection developed while the patient was in the hospital. In one of these, the result is classified as good; in the other, it is classified as poor.

Those cases in which the result is classified either as excellent or good need not be discussed. The situation is not the same, of course, with regard to those in which a fair or a poor result was obtained. They are of interest to us from the standpoint of improvement in technique.

We have found that the use of braided wire in the closure of the articular capsule does not interfere with the mechanics of the articulation. It gives an ample margin of safety, enough to permit moving the joint immediately after operation (a maneuver sometimes accomplished without any discomfort whatever) as well as exercising the knee without danger of dislocation.

On the basis of past experience, we no longer favor the practice of immobilizing the joint by means of a spica cast or any other method. Decubitus ulcer which, in these aged patients, can become torpid ulcer, atrophy of the muscles of the leg, ankylosis of the knee joint, cases of thrombophlebitis, all were observed from time to time when the above mentioned technique was in use.

In cases in which a Judet or stem prosthesis was inserted, the best results were obtained when there was perfect contact of the head of the prosthesis against a squared off femoral neck. Apparently, failure to square off the neck will contribute to loosening of the prosthetic stem.

In our experience, the Austin Moore intramedullary stem type of prosthesis has been highly satisfactory. It was used in practically all of our cases, with two outstanding examples: (1) a patient operated on at the age of 94 still living, has perfect motion, and is free of pain at his present age of 100 and (2) a miner who has undergone operation three times. At the time of the first operation, a Lorenzo type of prosthesis was inserted but broke down at the end of one year. On the occasion of the second operation, a Judet type was used. This too broke down, although not until the end of five years. Two years ago, on the third attempt, an Austin Moore type of prosthesis was inserted, and the patient has been working regularly in the coal mines ever since, free of pain and with no limitation of motion.

### Conclusions

1. The nonunion rate in subcapital fracture of the neck of the femur treated by internal fixation is extraordinarily high.

2. It has been our experience that the procedure of choice, particularly in the case of the older patient, is replacement of the head of the femur with a femoral prosthesis.

3. We have found the intramedullary type of prosthesis, such as the Austin Moore, superior to the stem type, of which the Judet is an example.

4. Prosthetic restitution offers no greater number of operative difficulties than might be met with in ordinary hip nailing. The period of hospitalization is not prolonged, and the patient is ambulatory, with full weight bearing, at the end of two weeks.

5. If the operative technique for femoral prosthesis as outlined in this paper is followed, the result should be excellent in a high per cent of cases.

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# Retraining the Physically Handicapped

Until recent years, the great majority of the medical profession looked upon rehabilitation as an extracurricular activity of medicine, something dealing with social work and vocational training, but something which had little concern, and which held but few implications for medicine. Today, however, that trend is being reversed, and although there are still many physicians who are unfamiliar with the aims and procedures of rehabilitation, more and more medicine is beginning to recognize that medical care cannot be considered complete until the patient with a residual physical disability has been trained "to live and work with what he has left."

Except in a few isolated instances, the physically handicapped person must be retrained to walk and travel, to care for his daily needs, to use normal methods of transportation, to use ordinary toilet facilities, to apply and remove his own prosthetic devices and to communicate either orally or in writing. These are such simple things that they are frequently overlooked, but the personal, vocational, and social success of the handicapped person is dependent upon them.

The practice of rehabilitation for the general practitioner, the orthopedic surgeon, or for any doctor, begins with the belief in the basic philosophy that the doctor's responsibility does not end when the acute illness is ended or surgery completed; it ends only when the individual is retrained to live and work with what is left. This basic concept of the doctor's responsibility can be achieved only if rehabilitation is considered an integral part of medical services. Any program of rehabilitation is only as sound as the basic medical and surgical service of which it is a part. The diagnosis and prognosis must be accurate, for it is upon them that the feasibility of retraining is determined.—Howard A. Rusk, M. D., in Rhode Island Medical Journal.

# Surgical Treatment of Peptic Ulcer*

*James E. Boggs, M. D., Bert Bradford, Jr., M. D., and Jean Roeland, M. D.*

A REVIEW of 131 subtotal gastrectomies for gastric and duodenal ulcer at Charleston Memorial Hospital during a seven-year period, 1952-58, is the basis of this report. A Polya procedure or a Hofmeister modification of the Billroth II operation was performed in 127 cases, whereas a Billroth I procedure was performed in four.

Most of the published reports on gastrectomy come from larger hospitals and university centers, but it seems probable that the majority of gastrectomies are performed in smaller hospitals where the volume of operations and the experience of surgeons are similar to those in our hospital.

Each record was reviewed with regard to age and sex of the patient, type of ulcer, indication for gastrectomy, findings at operation, operative procedure, correlation of the operative findings with the clinical and radiological diagnoses and postoperative complications, if any. Approximately 95 per cent of the patients were contacted either by questionnaire or through their physicians.

Conclusions are based on the study of these cases, personal experience, and a review of the recent surgical literature.

### Age Incidence and Duration of Symptoms

The average age of the patient undergoing partial gastrectomy for duodenal ulcer was 47 years; the youngest was 21 and the oldest was 83. The greatest number (41.7 per cent) were in the 40 to 49-year age group (Table I). The average age of the patient undergoing partial gastrectomy for gastric ulcer was 55; the youngest was 33 and the oldest was 68 years of age (Table II). The patient undergoing surgery for gastric ulcer was approximately ten years older than the patient with duodenal ulcer.

Duration of symptoms varied but most of the patients with duodenal ulcer had had symptoms for more than 10 years. The greater number with gastric ulcer had had symptoms for less than three years. Subtotal gastrectomy for duodenal ulcer was performed in 96 cases, in 81 of which the patients were males and in 15, females (a ratio of 5 : 1). The same procedure for gastric ulcer was carried out in 35 cases, with 26 males and 9 females (a ratio of 3 : 1). These data correspond closely to those in other reviews on the subject.


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**TABLE I**

**DUODENAL ULCER TREATED BY SUBTOTAL GASTRECTOMY**

**Age and Sex Distribution**

| | |
|---|---|
| Sex Distribution: | |
| No. of Cases | 96 |
| Females | 15 |
| Males | 81 |
| Age Distribution: | |
| 20 - 29 | 5 |
| 30 - 39 | 15 |
| 40 - 49 | 40 |
| 50 - 59 | 26 |
| 60 - 69 | 7 |
| 70 - 79 | 2 |
| 80 - 89 | 1 |

**TABLE II**

**GASTRIC ULCER TREATED BY SUBTOTAL GASTRECTOMY**

**Age and Sex Distribution**

| | |
|---|---|
| Sex Distribution: | |
| No. of Cases | 35 |
| Females | 9 |
| Males | 26 |
| Age Distribution: | |
| 20 - 29 | 0 |
| 30 - 39 | 4 |
| 40 - 49 | 11 |
| 50 - 59 | 11 |
| 60 - 69 | 9 |

### Indications for Operation

Tables III and IV show the indications for operation. Under "Intractability" is shown the number of cases in which symptoms were not

*From the Surgical Service, Memorial Hospital, Charleston, W. Va.

Submitted to the Publication Committee, April 2, 1960.

controlled by adequate medical therapy and in which there had been no perforation, significant obstruction, nor hemorrhage. "Obstruction" and "Bleeding" refer to cases in which the patient was admitted for treatment of these complications or in which the complications developed during hospitalization. "Combined" includes cases of those patients with ulcer symptoms not controllable medically and of those who gave a remote history of perforation, obstruction, or hemorrhage. Intractable ulcer was present in 57 cases (43 per cent). Moore and his associates[1] propose the term "progressive virulent ulcer" for

**TABLE III**

**INDICATIONS FOR SURGERY IN 96 PATIENTS WITH DUODENAL ULCER**

| | *No. of Cases* | *Per Cent* |
|---|---|---|
| Intractability | 43 | 44.7 |
| Bleeding | 9 | 9.3 |
| Obstruction | 10 | 10.3 |
| Combined | 32 | 33.3 |
| Acute perforation | 2 | 2.1 |

**TABLE IV**

**INDICATIONS FOR SURGERY IN 35 PATIENTS WITH GASTRIC ULCER**

| | *No. of Cases* | *Per Cent* |
|---|---|---|
| Intractability | 14 | 40 |
| Bleeding | 6 | 17.1 |
| Obstruction | 3 | 8.6 |
| Combined | 3 | 8.6 |
| Possible carcinoma | 9 | 25.7 |

the lesion now known as "intractable ulcer." Considering the repeated episodes of disability and the multiple hospital admissions of these patients, the term seems applicable. For the most part, they continue their medical treatment year after year, despite poor response to an ulcer regimen. Eventually they become discouraged, or a complication develops, and surgical consultation is sought.

In most of the cases in the series, there were persistent deformity and irritability of the duodenal bulb, with failure to improve on medical treatment, a state of affairs so consistent in the case of intractable ulcer, that surgery, it seems to us, should be considered if it persists after a fair trial of medical therapy. In view of the low surgical mortality and the favorable results offered by surgery, a more accurate appraisal of this group might have been gained from a joint review by surgeon and internist.

### Gastric Ulcer

Malignancy was suspected in 25 per cent of cases of gastric ulcer in which there was no response to adequate medical therapy. Many observers feel that gastrectomy should be performed in all gastric ulcer cases. It seems to us that fear of carcinoma does not warrant routine gastrectomy. Observation is justified in the young patient with free hydrochloric acid in the stomach or with prompt healing without recurrence on later x-ray study. Operation should be performed if there are radiological findings suggestive of carcinoma, or if there is failure to respond to trial medical therapy.

Welch and Schatzke feel that a ten day period of hospital medical treatment is sufficient to permit reasonably accurate x-ray reappraisal of the healing tendency in gastric ulcer. Subsequent x-ray studies are necessary to confirm continuance of progressive healing. The average length of time required for complete healing is 40 days. Surgery should be performed if the ulcer is not completely healed by the end of this time. Occasionally gastric ulcer will appear completely healed after a few weeks of medical treatment but x-ray studies one month later will show a recurrent crater.

In all cases, recurrent gastric ulcer should be resected. Achlorhydria after the injection of histamine in a case of gastric ulcer is strong evidence that the ulcer is malignant. Free hydrochloric acid, whether in normal or excessive amount, does not exclude malignancy. Size cannot be relied on in differentiating a benign from a malignant lesion. Occasionally benign gastric ulcer is large, while some malignant gastric ulcers may be small.

Two of the four patients in this study who expired had extensive surgery for large benign ulcer because the surgeon felt that they were malignant. In our opinion, radical gastric surgery is never justified unless the lesion is proven by biopsy to be malignant. A more conservative type of resection is appropriate in benign gastric ulcer as it results in a lower morbidity and mortality rate, fewer nutritional difficulties, and a decreased incidence of the dumping syndrome. In addition, the incidence of recurrence of marginal ulceration following surgery is much lower in gastric ulcer than in duodenal.[2]

There were 13 of the 96 patients who gave a history of previous perforation of duodenal ulcer (13.5 per cent), whereas only two of the 35 patients with gastric ulcer had had a perforation previously (8.6 per cent).

Emergency surgery for massive hemorrhage was performed in 12 cases. Nine patients (9.3 per cent) were bleeding from duodenal ulcer and three (8.6 per cent) from gastric ulcer. Saltzein and others[3] found that bleeding from gastric ulcer occurs one-fifth as frequently as from duodenal ulcer. Deaths attributed to gastric ulcer hemorrhage, however, occurs almost as frequently as that from duodenal ulcer.

### Types of Operations

Types of surgical procedure performed by our surgical group in the 131 cases are detailed in Table V. Partial gastrectomy, which consisted of resection of 60 to 70 per cent of the distal stomach, were performed in 127 cases. In the remaining four a Billroth I procedure (gastroduodenostomy) was carried out. From 1952 to 1957, the majority of partial gastrectomies consisted of a Polya modification of the Billroth II operation. Since 1957, most of us have been using the Hofmeister modification of the Billroth II technique.

In reviewing the literature it appears that the unpleasant side-effects of gastrectomy, with the exception of weight loss, are as common after Billroth I as after Billroth II.[4, 5] There is clinical evidence that less nitrogen and fat loss occurs via the stool after the Billroth I, resulting in less weight loss postoperatively.[6, 7] In our series of cases, weight loss after surgery most frequently was due to inadequate intake which, in turn, usually was due to the dumping syndrome, and only a few patients failed to realize the importance of multiple, small feedings.

**TABLE V**
**OPERATIVE PROCEDURES**

| | |
|---|---|
| Polya antecolic | 57 |
| Polya retrocolic | 10 |
| Hofmeister antecolic | 36 |
| Hofmeister retrocolic | 24 |
| Billroth I | 4 |

It will be noted that vagotomy, in combination with gastroenterostomy, pyloroplasty, or antrectomy, was not performed in any of these cases. Recent reports stress the improved results and lower morbidity and mortality rates of vagotomy and other supplemental emptying procedures.[8, 9, 10, 11] It frequently is difficult, however, in the published report, to distinguish between established fact and unproved conviction of enthusiasts. It is obvious, nevertheless, that antrectomy with bilateral infradiaphragmatic vagus resection is coming more into favor. The combination appears as physiological as a more radical gastric resection. In subtotal gastrectomy one tries to remove the acid secreting area, whereas antrectomy-vagotomy attacks the mechanism that stimulates acid secretion. Experiments by Dragstedt[12] and Sauvage[13] and their respective colleagues, indicated that the two main stimulators of the secretion of hydrochloric acid are the vagus nerves and a substance elaborated by the antrum. Experimental work by Harrison and co-workers[14] showed that the antrum does not act as a stimulator of hydrochloric acid secretion from fundic glands if its mucosa is exposed to a high acid environment. It appears to secrete instead an inhibitor of hydrochloric acid secretion, the reverse of what it does when exposed to an alkaline or weakly acid environment. This probably explains why exclusion operations that leave antral mucosa exposed to alkaline duodenal juices so often lead to poor results. To prevent elaboration of gastrin, it is necessary to remove the distal 40 to 50 per cent of the stomach. The line of resection should be above the incisura on the lesser curvature side. The procedure in most cases has the advantage of allowing for surgical removal of the ulcer and preservation of the body of the stomach, thus decreasing the occurrence of the various postgastrectomy syndromes.

Whether or not antrectomy with vagotomy will fortify the patient against recurrent ulcer any more surely than simple 75 per cent subtotal gastrectomy must await the further passing of time.[15] Rather brief follow-up periods indicate that the ulcer recurrence rate well may be the lowest of all. Reported results of the antrectomy and vagotomy combination have been so satisfactory that we feel it probably is the operation of choice in most cases, for treatment of chronic duodenal ulcer.

In the elderly patient with obstruction and low acid secretion, posterior gastroenterostomy usually is adequate. In a small per cent of cases, acid secretion will increase following relief of the obstruction.[6] The addition of vagotomy may be necessary to prevent formation of a stomal ulcer in cases with significant acid secretion. A few surgeons favor vagotomy, pyloroplasty or gastroenterostomy, especially for the poor risk patient, and in other cases in which the pathology is such that even antrectomy would be a hazardous procedure.

Patients with multiple recurrences in atypical jejunal locations or with remarkably high overnight acid outputs, may have an islet-cell tumor of the pancreas (Ellison-Zollinger Syndrome).[16, 17] In such cases, radical gastric resection will be required.

Dragstedt and others[18] emphasize the importance of overnight estimation of total hydrochloric acid secretion in determining true hypersecretion since the latter may not be revealed by gastric juice samples taken at random. The titration of gastric acidity has significance in several situations. Low or absence of acid secretion raises the possibility of gastric cancer. Low acid values in the elderly patient with obstruction due to duodenal ulcer will favor posterior gastroenterostomy. If night secretion exceeds 20 meq.

of hydrochloric acid in a 12 hour period, vagotomy with antrectomy is indicated.

Regardless of the foregoing consideration, the surgical anatomy, condition of the patient, and location of the ulcer may dictate the type of operation called for.

### Postoperative Complications

There were 30 immediately postoperative complications. In some cases, more than one complication developed. Of this number, 11 were pulmonary, two were evisceration, and two were leakage of the duodenal stump. Obstruction of the stoma developed in two cases. One responded to nasogastric suction, the other required additional surgery. The perforated duodenal stump eventually closed with conservative treatment, which consisted of suction to a catheter placed in the spontaneous fistula tract, semi-Fowler's position, aluminum paste to decrease skin excoriation, and replacement of fluids and electrolytes intravenously. One patient with a duodenal leak underwent additional surgery for a subphrenic abscess. Difficulty in duodenal stump closure was encountered in each case but no type of drainage was utilized at the time of surgery. In approximately 15 per cent of the 131 cases, however, the duodenal stump was intubated or a Penrose drain was placed near the duodenal stump closure. In 2 cases (6.6 per cent), gastric hemorrhage developed postoperatively. Nasogastric suction was used in one; the other required reoperation. Bleeding was from the anastomosis (gastrojejunostomy), evidently from the submucosal vessels of the stomach, which is the most frequent site.

**TABLE VI**
**POSTOPERATIVE COMPLICATIONS**

| *Type of Complication* | *No. of Cases* |
|---|---|
| Pneumonia | 4 |
| Atelectasis | 7 |
| Evisceration | 2 |
| Wound infection | 2 |
| Phlebitis | 2 |
| Gastric hemorrhage | 2 |
| Partial stomal obstruction | 2 |
| Leakage of duodenal stump | 2 |
| Diarrhea | 2 |
| Ileus | 2 |
| Subhepatic abscess | 1 |
| Peritonitis | 1 |
| Incisional bleeding | 1 |
| Total | 30 |

### Postoperative Deaths

There were four (3.06 per cent) deaths in the entire series of 131 cases (Table VII). One patient had surgery for massive hemorrhage secondary to a gastric ulcer. He was never out of shock during or after surgery, in spite of repeated transfusions. He expired 20 hours after surgery. In another case emergency surgery was necessary because of massive hemorrhage secondary to a gastric ulcer. The patient died on the ninth postoperative day. Death was attributed to uremia and chronic pyelonephritis. In the third case total gastrectomy, splenectomy and resection of the head and body of the pancreas had been done for a malignant-appearing gastric lesion without frozen section. Pathological examination of the specimen revealed a large, penetrating, benign gastric ulcer. The patient expired on the second day after surgery, and autopsy permission was not obtained. A frozen section at the time of surgery probably would have prevented so radical an operation, resulting in death. In the fourth case, total gastrectomy was done for a large gastric ulcer which penetrated into the pancreas and transverse mesocolon. The patient expired on the seventh postoperative day. Death was attributed to atelectasis, bronchopneumonia and septic shock.

**TABLE VII**
**MORTALITY IN 131 CASES**

| *Number* | *Cause* |
|---|---|
| 1 | Hemorrhage shock |
| 1 | Pneumonia and peritonitis |
| 1 | Uremia and chronic pyelonephritis |
| 1 | Atelectasis and bronchopneumonia |
| Total 4 (3.06%) | |

In summary, there were 2 cases with massive gastric hemorrhage requiring emergency surgery and 2 diagnosed by x-ray as gastric carcinoma which were large, penetrating, gastric ulcers. There were no deaths in those cases in which elective or emergency partial gastrectomy was done for duodenal ulcer.

### Preoperative Roentgenographic Studies

Preoperative gastrointestinal roentgenographic examination was carried out in 125 cases. In the remaining six, emergency surgery without barium studies was necessary because of massive gastrointestinal hemorrhage. In 113 of the 125 cases the preoperative roentgenographic interpretation was correct (90.4 per cent). This was confirmed at surgery or on pathologic examination, or both. In 9 cases, an ulcer was seen by x-ray before surgery but there was no evidence of ulcer at surgery nor on pathologic examination of the resected specimen. In one case a posterior penetrating ulcer was present at the time of surgery but barium studies were reported as normal. In two cases, the gastric lesion was interpreted by x-ray as gastric carcinoma, in which large penetrating gastric ulcers were found at surgery.

### Antibiotics and Blood

Antibiotics were used in the immediate postoperative period in 70 cases (53.4 per cent). There were only a few instances in which the drugs were clearly indicated. In the majority of cases in which complications developed after surgery, prophylactic antibiotics were used. We feel that antibiotics are not indicated in elective gastrectomy unless there is chronic pulmonary sepsis or some other extraperitoneal infection.

Five hundred to 1500 cc. of whole blood was used in 91 cases (68.8 per cent). It has been estimated that the blood loss during an elective subtotal gastrectomy is 200 to 400 cc. If the preoperative hemoglobin and hematocrit are normal and the operation loss is less than 500 cc., the risk of a single transfusion exceeds the benefit. The transfusion should be given after the patient reacts from the anesthetic when it is necessary to administer only one pint of blood.

### Evaluation of Follow-Up Studies

The late results of partial gastrectomy were studied via questionnaire in 85 cases (66 per cent). The family physician or surgeon was personally contacted in the remaining 34 per cent. Patients were questioned in detail concerning weight change, recurrence of ulcer symptoms, eating habits, bowel habits, smoking, and whether they felt improved or worse since operation (Table VIII).

**TABLE VIII**

**RESULTS OF FOLLOW-UP STUDIES**

| | *No. of Cases* |
|---|---|
| Weight | |
| Gain or no change | 88 (73.4%) |
| Loss | 32 (26.6%) |
| Dumping Syndrome | 24 (20%) |
| Diet | |
| Regular | 100 (80%) |
| Special | 20 (20%) |
| Frequency of Feedings | |
| Three times a day | 80 (66%) |
| Three to five times a day | 40 (23%) |
| Pain | |
| Ulcer-like pain | 3 (2.5%) |
| Distress with overindulgence | 14 (11%) |
| No pain | 103 (86%) |
| Personal Feeling | |
| Better | 115 (95%) |
| Same | 3 (2.5%) |
| Worse | 2 (1.6%) |

Weight loss following operation occurred in 32 (26.6 per cent) cases, whereas in 88 (73.4 per cent) cases, the patient gained or failed to lose weight. The average weight loss in the 32 cases was 18 pounds.

In 24 (20 per cent) cases, the dumping syndrome developed. For the most part, however, it could be classified as mild in type. In 15 cases (62 per cent of those in which the dumping syndrome developed) in which there was more than a 20 pound weight loss, the dumping syndrome appeared to be the factor most responsible. Review of the hospital records and the questionnaires disclosed a high index of nervousness in the greater number of cases.

Many patients with gastrointestinal symptoms following gastric surgery are said to have a "dumping syndrome" when actually the symptoms are due to some other condition. The syndrome is characterized by the occurrence of one or more of the following sensations within the first half-hour after eating: nausea, weakness, faintness, sweating, epigastric fullness or pain, palpitation and drowsiness.

In most cases, the patient was on regular diet for three meals a day. In 86 per cent, the patient was free from abdominal pain and the ulcer syndrome was relieved. In 3 cases (2.5 per cent) ulcer-like pain similar to the preoperative pain developed after a period of one year. In 2 of these (1.6 per cent), marginal ulcer was present. In one case vagotomy was performed, with relief of pain and healing of the ulcer.

Patients were questioned specifically with regard to gastric condition postoperatively as compared with the preoperative status. Of those who responded to the questionnaire, the majority reported improvement since operation. Three reported that the gastric condition was about the same, whereas two felt that it was worse since operation.

### Summary

A series of 131 cases of gastric resection for duodenal and gastric ulcer is reviewed. Of this number, there were 96 cases in which surgical treatment for duodenal ulcer was carried out, with no mortality. Subtotal gastrectomy in the treatment of duodenal and gastric ulcer offers satisfactory results in 85 to 90 per cent of cases. A plea is made for less radical surgery in the treatment of benign peptic ulcer. Of the four deaths in this series of cases, two occurred as a result of radical gastric surgery for benign lesions. In all gastric lesions, frozen section should be done prior to resection.

The combination of vagotomy and antrectomy appears at present to be the best procedure in the treatment of duodenal ulcer requiring surgical intervention. In the case of the poor risk patient, vagotomy and some type of emptying procedure is preferable.

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# Causation of Psychiatric Illness

The earliest notion was that psychiatric illness was somehow related to supernatural things. Not until Hippocrates' time were the mental illnesses regarded as "natural phenomena." Hippocrates, speaking of epilepsy, said, "It thus appears to me in no way more divine, not more sacred than other diseases, but has a natural cause from which it originates like other affections . . . They who first referred this disease to the gods appear to me to have been just such persons as the conjurors, purificators, mountebanks and charlatans now are, who claim great piety and superior knowledge. Such persons thus . . . use divinity as a pretext and a screen for their inability to afford any assistance."

It has taken a long time for the pendulum to swing from the ancient concept of supernatural causation to the acceptance of all mental diseases as natural phenomena. The process is still not complete. Hippocrates, I think, gave the correct reason—that there is still too much "inability to afford any assistance."

When there are many remedies for diseases, it is likely that none is effective to a satisfactory degree. In my time intrathecal horse serum, lithium salts, metrazol, acetyl choline, carbon dioxide, and nitrogen have all been used for the treatment of schizophrenic patients. Electroshock and insulin shock therapy persist, although interest has shifted to tranquilizing drugs. Granted that each form of shock treatment has been the best available and that each taught something about mental diseases, there was a disturbing, nonspecific character about them. In spite of wires and vials and syringes—and the poses of physicians—all such procedures are disturbingly related to the older shock treatment, the ducking stool.

The present surge of research on psychiatric disease will, I am sure, move the pendulum rapidly toward the consolidation of Hippocrates' naturalistic position. Knowledge of physiology of mental illnesses, involving biophysics and biochemistry, should keep growing; ceruloplasm, cerebrocides, serotonin, radio-active tracer substances and fluorescent antibodies are examples of such types of research.—Texas State Journal of Medicine.

# Special Article

# The Huntington State Hospital Vocational Rehabilitation Unit

*Edith Cserny, M. D., and F. Ray Power*

"A progressive, pioneering development in the fields of mental health and rehabilitation."

The words quoted above are the essence of a report by national leaders in the United States Department of Health, Education and Welfare to describe the advances made in West Virginia in the area of psychiatric rehabilitation. The adoption of the new concept in the treatment and rehabilitation of mental patients in state hospitals, which embraces the philosophy that every hospitalized patient is entitled to services that will afford him the opportunity to return to his community as an independent and self-sustaining member of society, has been made possible at Huntington State Hospital by the establishment of a Vocational Rehabilitation Unit.

### Purpose of the Unit

The Huntington State Hospital Vocational Rehabilitation Unit is a cooperative development whereby Huntington State Hospital, a unit of the West Virginia Department of Mental Health, and the West Virginia Division of Vocational Rehabilitation operate a program of rehabilitation services for mental patients. Such a joint undertaking is unique in its administration and operation. Although other states and the District of Columbia are using the project at Huntington as a model by which they plan to organize their own programs, the unit in West Virginia marks one of the first, if not the first, times two such agencies have merged their resources so closely in an effort to provide a direly needed but peculiar service that neither agency can provide entirely alone.

The unit is designed as an integral part of the hospital to evaluate the vocational needs and potentialities of patients; to assist patients in gaining self-understanding through counseling, assignment to one of the rehabilitation evaluation facilities, and by assignment to various duties in the hospital industry as prescribed by the staff physicians; to insure patients of services necessary to accomplish their rehabilitation, including job placement and follow-up; to assist relatives and the community in gaining the understanding necessary to provide an environment conducive to the vocational rehabilitation of mental patients.

Submitted to the Publication Committee, March 7, 1960.


## *The Authors*

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### Physical Plant

New construction was necessary in order to house the unit staff and establish training facilities. A suite of five offices suitable for housing unit personnel was constructed and equipped in the basement of the hospital administration building.

For the domestic arts section a model home was constructed and furnished in the basement of a ward building. The model home consists of a living room, kitchen, two bedrooms, utility room and bath.

An industrial arts section consisting of a shop equipped with all the machine tools and equipment suitable for the establishment of a complete woodworking unit is located in the same basement as the model home.

Since grooming and personal appearance constitute an important factor in readjustment, a combination dressing room, shower and toilet was constructed next to the shop for the benefit of the men.

To provide a convenient entrance to the basement housing the evaluation and training facilities, it was necessary to construct concrete steps with a metal handrailing.

### Scope of Services Provided

Services provided patients within the hospital include:

1. Vocational diagnostic and evaluative services.
2. Vocational guidance and personal adjustment counseling.

3. Physical restoration not provided under the hospital treatment program, but necessary to accomplish the vocational goal.
4. Evaluation and training in industrial arts or domestic arts.
5. Assignment and follow-up in the industrial therapy program.
6. Job placement and follow-up.
7. Transfer of patients to field counselors in patient's home community.

It is the function of the unit to receive referrals from hospital staff members as well as self-referrals, carry out necessary investigation and evaluation and accept referrals for hospital work assignments. For those referred, it is the goal of the unit to assist each patient in establishing suitable vocational objectives and to provide, for those for whom it is feasible, within the hospital or community, the services found to be necessary in preparing the patient for return to the community.

Prior to the establishment of the rehabilitation unit at the hospital, patients performed various tasks in all areas of the hospital but the program was not organized and the only goal was that of production. Industrial therapy was made a responsibility of the unit. A complete job analysis survey was made of each job in the hospital performed by patients and a permanent job specification file established. Referral mechanics were established that were meaningful to the ward physicians and unit personnel so that the unit could assign patients to jobs on the basis of what is best for the patient. This results in therapy for the patient, worthwhile training, and better accomplishment of the work than ever before.

The work evaluation areas, industrial and domestic arts, provide an opportunity for evaluating work habits, attitude and ability, and for further study of the personality as it relates to the vocational goal. Training is provided in these areas. In the shop for men, detailed training in a specific area is at a minimum. Mainly, general training that would be applicable to any vocational goal is available in the shop. In the domestic arts unit, in addition to evaluation, definitive training is provided for homemakers, housekeepers, maids, and waitresses and other workers in the service area.

The desired results that have been obtained by the unit have been basically threefold, as follows; (1) vocational counseling, evaluation, training and placement, (2) therapy that concomitantly helps to speed recovery and (3) useful adjustment to prolonged hospitalization through the industrial therapy program.

Before the advent of the unit, when a patient was released from the hospital there was no further contact with him. Now a most valuable service performed by the unit is that of transferring cases to field counselors. Every patient that is released from the hospital with even a fair vocational prognosis (including housewives and family workers) is referred to a rehabilitation field counselor in the patient's home area. The field counselor sees the patient in order to assist him in making a vocational and social adjustment. This may include job placement, training, medical service, if needed and not provided by the hospital, and follow-up on the job for a continued adjustment. Outpatient therapy is provided by a private physician in some cases, if recommended by the hospital staff. The field counselor performs an additional valuable service by sending reports back to the hospital on patients transferred to him.

### Financing

Funds for the operation of the unit are provided on a 70-30 per cent matching basis. Seventy per cent of the budget is made available by the West Virginia Division of Vocational Rehabilitation. The Huntington State Hospital contributes 30 per cent through the prorating of salaries of hospital personnel assigned to work with the unit.

In reality, the financing of the unit budget works out most advantageously for the hospital. The work performed by hospital personnel assigned to the rehabilitation unit is a vital part of the total hospital function of providing all possible services to patients.

### Staff and Administration

The unit staff is composed of the following personnel:

Director (Superintendent or Clinical Director of Hospital)
Administrative Assistant
Staff Physician (3—part time)
Psychologist
Social Work Aide and Training and Placement Specialist
Vocational Counselor
Industrial Arts Supervisor
Domestic Arts Supervisor
Secretary
Jr. Stenographer

Administration of the unit is under the overall direction of the hospital superintendent with the clinical director or superintendent acting in the capacity of unit director. Members of the unit staff on the hospital payroll, among whom are included the physicians, the psychologist and the social work aide, are assigned by the hospital superintendent. The Director of the Division of Vocational Rehabilitation, in mutual agreement

with the superintendent or director of the unit, assigns all personnel not on the hospital payroll. The administrative assistant of the unit serves in the capacity of the department head and is responsible to both agencies for the operation of the unit. All personnel assigned to the unit are under the provisions of the state merit system.

This unit is operated in conformity with the provisions of Public Law 565, 83rd Congress; Article 10-A and B, Chapter 18, Code of West Virginia; and the West Virginia Plan for Vocational Rehabilitation, and is under the general supervision of the Director of the Division of Vocational Rehabilitation.

**Recapitulation of Results in Fiscal 1958-59**

A complete staff was not secured until late in the first half of the year. Construction of the evaluation and training areas was completed in February.

Accomplishments can be viewed statistically from the figures below. Some of the placements listed were made in cooperation with the Huntington branch office.

| | |
|---|---|
| Patients referred to unit | 521 |
| Patients accepted for service | 503 |
| Initial interviews | 472 |
| Unit job placements | 39 |
| Transferred to field counselors | 169 |
| Job placements to field counselors | 79 |
| Reported "closed" as satisfactorily employed | 49 |
| Psychological testing | 145 |
| Vocational counseling | 432 |
| Adjustment counseling | 146 |
| Social histories | 44 |
| Social case work | 76 |
| Industrial arts evaluation & training | 79 |
| Domestic arts evaluation & training | 53 |
| Assigned to industrial therapy program | 537 |

**Outlook for the Future**

One of the most encouraging developments in the field of mental health and rehabilitation in recent years has been the establishment of rehabilitation houses. The rehabilitation house serves as an intermediate step between the hospital and the community for those patients for whom a clean break is too stressful.

There are three types of patients that need this extra step on the road back to independent living. First, it will serve patients who have no home to which they can return during the initial adjustment period; second, it will serve the long-term chronic patient who has been out of contact with general society during his readjustment period; third, it will enable those patients whose former environments have been precipitating factors in their illness to become adjusted in a new community.

The West Virginia Division of Vocational Rehabilitation has made application to the Federal Office of Vocational Rehabilitation for a federal grant to establish two rehabilitation houses in Huntington, one for men and one for women. This would be an extension of the work of the rehabilitation unit at the hospital and would make its work complete. If the application is approved (and it seems likely it will be) West Virginia and Huntington State Hospital will be in the enviable position of being able to provide services to all mental patients who can benefit from them, and opportunity to again become independent members of society.

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## Rehabilitation — A Community Challenge

In considering the broadening horizon of rehabilitation, there are tremendous challenges involved. Only the "surface has been scratched" in the development of community resources and individual responsibility for more effective rehabilitation programs. These challenges are not going to be met successfully merely by creating vast Federal or State programs, by building big impressive medical centers full of expensive and largely unused equipment, by a patronizing and "socialistic" approach to medical and therapeutic care. They will be met rather by the earnest, dedicated efforts of staff people and volunteers from many disciplines and interests, involved in simply organized practical community programs, which seek cooperatively to meet the needs of the community and its disabled people.

All, whether in public or private agencies and institutions, need to emerge from the cocoon of limited programs, small thinking and doing, lack of imagination and selfish agency interest into a world of concern for people and their real needs in the area of human disability.—W. Scott Allan in Journal, Maine Medical Association.

# WVU Teaching Hospital

Excavation Work Started
October 1957

First Patients Admitted
August 1960

# The President's Page

## A Dream Comes True

On the eighth of October, I represented the State Medical Association at the dedication of the Teaching Hospital at the Medical Center in Morgantown. It was a source of great pride to me and inspiration to the staff of the School and Hospital to see so many doctors in the audience. In his opening remarks, University President Elvis Stahr remarked that there were at least 200 doctors in the audience, none of whom could help him with his "common cold."

To all of us the occasion brought the fulfillment of a dream we have long had for our State. No one, whether he be native or out-of-stater can make the turn off University Avenue and catch the first glimpse of the Medical Center and Hospital without experiencing a thrill mingled with high hopes for the future of West Virginia.

A statement was made a few days earlier at our 13th Annual Rural Health Conference at Jackson's Mill that there are several physicians in our state over 70 years of age who are handling large rural practices alone. We must be looking for assistance to and replacement for these men. This will have to come from the young men and women of West Virginia. We must interest and support those who are capable and desirous of studying medicine but are financially unable to do so.

We were happy to hear that the Van Liere Loan Fund is already providing financial assistance for students in the School of Medicine. This Fund, as many of you know, was established by the West Virginia University Medical Alumni to honor the retiring Dean, E. J. Van Liere. Any one desiring to make a contribution to this Fund may make his check payable to the West Virginia University Foundation for the Van Liere Fund. It is going to take more than tax money to keep our Medical School abreast of other medical schools in the country and it is going to take some monetary inducements equal to those offered in other states to keep our boys and girls here for their education and life's work.

The Fayette County Medical Society has established a separate loan fund, administered by the Society, for the support of a student from Fayette County. The Kanawha Medical Society contributed $2,100 to the Van Liere Fund, and the Auxiliary to the Kanawha Medical Society has given $1,000 to the Medical Library Fund. Here, again, tax monies will not do the total job. We must augment these funds each year if our students are to have adequate library facilities.

President Stahr announced at the dedication that the Charleston Foundation, which was established and headed by Dr. G. B. Capito, has endowed a Chair in Cancer Research. This is the first Chair that has ever been endowed for our State University. We are all grateful to Doctor Capito and proud of his fine contribution. Dr. Sobisca S. Hall of Clarksburg has donated some equipment to the new Hospital. We are sure these gifts will inspire others of our profession to make some contribution to our school either in loan funds, library funds, or by some other method.

It would seem that most of the things that I have discussed in this letter will cost money. Now, I would like to add one last thought that if neglected may cost you your last free day in the practice of medicine. Don't forget to vote on November 8. Study the issues and know where the candidates stand. Make it possible for the members of your office staff to vote.

As this is the month of Thanksgiving, may I wish for you and yours all the blessings of the Season.

John W. Hash

John W. Hash, M. D., President

# THE WEST VIRGINIA MEDICAL JOURNAL

*Official Organ of the West Virginia State Medical Association*

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.



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*Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.*

*Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.*


# EDITORIALS

## THE MEDICAL EXAMINER'S BILL

The Council of the West Virginia State Medical Association has unanimously recommended to the Legislature that the Medical Examiner System be established in West Virginia. A proposed bill, originally drafted under the supervision of the Section on Pathology of the State Medical Association, is now ready for introduction at the January session of the Legislature. This bill follows closely the laws now in force and working out so well in our neighboring states of Maryland and Virginia, and all the "kinks" in the Iowa statute appear to have been entirely omitted.

The coroner system now in vogue is outmoded in West Virginia, and everywhere else in America for that matter. As the density of population increases the complexity of the sociological picture increases also. We have seen one statement to the effect that the ratio of increase is as the square of population density. Whether that be a correct estimate or not, it is obvious that density of population is a large factor in the complexity of modern society, modern law, and present day law enforcement.

Accuracy in vital statistics is a *sine qua non* in our present day life; not only as a matter of knowing about the population generally, but as necessary to crime detection, the settlement of estates, and the correct adjustment of insurance claims. It is likewise a matter of community morbidity and the better understanding of area health, the heredity of disease tendencies, and the upbuilding of a more healthful populace.

A recent publication of the American Medical Association estimates that one in five Americans now living will die under circumstances requiring an official investigation into the cause of death, and asks the question: "Was it 'natural causes', accident, suicide, or even murder?" Another estimate we have seen is that between 3,000 and 10,000 murders occur annually in the United States and go forever undiscovered or are detected too late to make prosecution feasible or often even possible.

The coroner system, as we know it today, is an outgrowth of the office of "Crowner", established during the reign of Richard Coeur de Lion, in 1194 A. D., and the original duty seems to have been to see that the proper taxes due the Crown were remitted. However, it soon came to embrace other work for the sovereign including the investigation of unusual and unexpected deaths. In the current Anglo-American local governmental status, only the sheriff—originally the shire reeve—antedates the coroner who came into being because the King suspected that the sheriff was not collecting and remitting all the royal revenues to which the Crown laid claim. North Carolina's first coroner law, enacted in 1776, was a verbatim copy of one passed in England in 1275, 501 years previously.

The proposed West Virginia bill does not abolish the office of coroner, but requires that the cause of death under investigation be established and certified to by the State Medical Examiner or his local representative, the Deputy Medical Examiner. This will place determination of the cause of death in medical hands whereas under the current system the majority of coroners in the United States are laymen. For instance, in 1958, in California only 3 of the 58 coroners were physicians; in Alabama, 3 of the 67; and in Colorado 11 of the 63.

Of course, the Medical Examiner System will cost more than the present set up, but it will be correspondingly worth much more than its actual cost.

We are heartily tired of hearing West Virginia referred to as a "backward state," and trust the Legislature will take this "forward" step.

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**THE EFFECT OF HYPOXIA ON THE HEART**

It has been shown that during progressive hypoxia the first outstanding dynamic effect is an acceleration of the heart. There is reason to believe that the dominant factor is the reduction in vagal tone, but presumably an adrenergic influence is also involved because acceleration still occurs during hypoxia after vagotomy. Wiggers (C. J. Wiggers, "Reminiscences and Adventures in Circulation Research." New York: Greene and Stratton, Inc., 1958 p. 319) feels that an appreciable degree of hypoxia has a stimulating effect on the myocardium, which produces a tonic effect resembling that realized following a therapeutic dose of digitalis.

The myocardial stimulation produced experimentally by hypoxia persists until the air contains only from 8 to 6.5 per cent oxygen. At this percentage of oxygen the arterial-blood oxygen saturation is between 50 and 35 per cent which corresponds to a simulated altitude of approximately 30,000 feet. At about this level a circulatory crisis develops rather rapidly. The systolic and diastolic pressures decline, the pulse pressure diminishes, the central venous pressure rises sharply, and the heart decelerates. Wiggers feels that the circulatory crisis is essentially an acute congestive heart failure due to the depressant effect of hypoxia on the myocardium.

The conduction in the ventricle has been observed to be unimpaired until the percentage of oxygen inspired is reduced to approximately 8 per cent. In the rather early stages of severe hypoxia the conduction rate often increases, but this is followed by a lengthening of the A-V conduction. Intraventricular conduction is less affected. It is thought that severe degrees of hypoxia directly affect the conduction tissue.

It has been known for some time that coronary flow is markedly increased by sharp degrees of hypoxia. For example, in 1940 Green and Wegria (H. D. Green and R. Wegria, Am. J. Physiology, 131, 271, 1940) showed that pulmonary ventilation with a gas mixture containing from 5 to 7 per cent oxygen increased coronary flow a hundredfold. It is obviously greatly to the advantage of the organism that coronary flow is augmented by hypoxia.

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**KUDOS FOR OUR EYE PHYSICIANS**

Much has been written on the desirability of ophthalmologists playing a more important role in the life of their local communities—particularly in civic enterprises in the field of health and eye care. One of the most constructive enterprises of this sort—one indeed that might well be an example for our colleagues in every part of the country—is the publication of a "Manual for Coordination of Activities of The West Virginia Lions Sight Conservation Foundation, Inc. and The West Virginia Academy of Ophthalmology and Otolaryngology." Preparation and publication of this Manual is the product of a friendly liaison between the leaders of the Lions Clubs and the eye physicians in West Virginia. The Manual has been enthusiastically accepted by the state organization of the Lions in that state at a meeting held early in June, 1960.

"General Aims" of the liaison which brought about the Manual are as follows:

"1. To encourage a better understanding and permanently harmonious relationship between the members of the West Virginia Lions Clubs and the eye physicians of the State.

"2. To facilitate joint efforts of West Virginia Lions and physicians in all aspects of sight conservation and rehabilitation.

"3. To provide specific methods of procedure for most efficient handling of the affairs of mutual concern to eye physicians and the Lions Sight Conservation Foundation."

Following an introductory discussion of the need for coordination of the activities of voluntary health agencies with those of the medical profession, a procedure is set forth for the discussion of subjects of common interest between the Lions of West Virginia and the eye physicians of that state. Problems of common interest not involving policy are to be worked out as far as possible on a local or regional basis, but if they

cannot be settled locally either party may ask that the problem be referred to the State Academy of Ophthalmology and the Board of Trustees of the West Virginia Lions Sight Conservation Foundation. Matters of common interest involving policy are to be referred to the state organizations for their decision.

The Manual then takes up the problem of corneal transplants and sets forth five primary considerations to govern the activity of the Lions Foundation in procuring eyes for eye banks. There is an interesting explanation as to what matters can and cannot be publicized, in the light of medical ethics. Mechanisms are outlined regarding the operation of eye banks, including the taking of pledges from prospective eye donors, arrangements with physicians for removal of donated eyes, transportation and other problems. A list of eye banks in West Virginia and neighboring states is included.

There follows a section on eye disease case finding, in which three different types of case finding are discussed: (1) Eye screening surveys of groups, particularly school children, pre-school children and factory employees; (2) glaucoma case finding; and (3) the finding of needy persons with medical and surgical eye conditions requiring treatment.

In regard to eye screening surveys the point is made that school eye screening should be carried out by others than physicians or optometrists, for several reasons: (A) To avoid the false impression that a screening survey is equivalent to adequate eye examination; (B) To obviate professional jealousies; and (C) Because children will cooperate more readily with a school nurse or lay person.

The purposes and limitations of glaucoma surveys are carefully explained.

The physicians have pledged their utmost cooperation with the Lions Sight Foundation in providing necessary care for needy patients—particularly for those who cannot qualify for any public aid.

Interesting practical discussions follow on such topics as visual aids for the needy; education in sight conservation; and eye research.

The final section of this Manual is devoted to a detailed discussion and outline of an agreed form of eye testing program for schools, including suggested forms for the vision screening survey, the screening report to parents and the physician's report of the eye examination to the parent.

The Foundation has expressed its congratulations to Dr. Ralph W. Ryan of Morgantown, West Virginia, a leader in this liaison effort. We commend this to the attention of physicians who are concerned with eye care, and especially to physicians who are members of local Lions Clubs.—*News Bulletin, The National Medical Foundation for Eye Care.*

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**STUDENT ESSAY CONTEST**

Elsewhere in this issue of *The Journal* we are carrying a news note relative to the 1961 Essay Contest for Undergraduate Medical Students throughout the world. The contest, a project of the American College of Chest Physicians, is designed to stimulate interest and research in the physiology, the pathology, and the therapeutics of the contents of the chest cavity. These have been carried on since 1950, and this is the twelfth in the series.

In the 1960 contest, D. Jackson Coleman, University of Buffalo School of Medicine, won the first prize; Robert Liberman, Dartmouth Medical School, Hanover, New Hampshire, was the winner of the second prize; and the third went to Joseph Bernard Garston, University of Durham Medical School, Newcastle-on-Tyne, England.

Under the rules governing the contest, preceptors are permitted for the purpose of guiding and giving professional advice to the students in the preparation of the essays.

This contest is one of the best methods for stimulating medical students to become interested in diseases of the chest. We trust that some members of the student body at the West Virginia University School of Medicine may be stimulated to submit an essay. The contest closes April 1, 1961.

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### Peculiar Problems of Aging

Make no mistake, age does bring some peculiar kinds of problems such as that of loss of mate and friends and sheer impairment of one's bodily faculties Certainly these are problems that no amount of money, improved health and housing and adult education can minimize, but these are also problems which are inevitable, at least as yet.

These, however, are not only the problems of age; they are the inevitable liabilities and limitations of life itself. Though they too are more pronounced among the aged, the only possible protection against these problems is to recognize them as inevitable aspects of life and to begin very early in life careful preparation for aging. Here both child and adult education must be coordinated to prepare people for the unavoidable limitations and liabilities of aging.

This is all that can be done about this order of problem, but even this is not now being done in any comprehensive way.—Mel J. Ravitz, Ph. D., in Industrial Nurses Journal.

# GENERAL NEWS

## WVU Teaching Hospital Dedicated In Impressive Ceremonies

More than 500 persons, including a large number of West Virginia physicians, attended dedicatory ceremonies for the new Teaching Hospital at the West Virginia University Medical Center in Morgantown on October 8. The ceremony was held outdoors and the new 522-bed Hospital formed an impressive background for the speaker's platform.

University President Elvis J. Stahr, Jr., presided during the ceremony and the principal speaker was

Dr. Thomas L. Harris of Parkersburg, a past president of the West Virginia State Medical Association, received an honorary Doctor of Science degree during the dedicatory ceremonies for the WVU Teaching Hospital. He is shown with Mrs. Harris at the conclusion of the formal program.

Dr. James A. Shannon, Director of the National Institutes of Health, United States Public Health Service. He is also an Assistant Surgeon General of the Public Health Service.

Other speakers included Governor Cecil H. Underwood, former Governor Okey L. Patteson, and Dr. Irvin Stewart, president of the University at the time the Medical Center was conceived and during the greater part of its basic construction.

### Dr. Thomas L. Harris Honored

The honorary degree of Doctor of Science was conferred upon Dr. Thomas L. Harris of Parkersburg, a past president of the West Virginia State Medical Association, who served for many years as both a member and president of the University Board of Governors. Doctor Shannon, the principal speaker, was also awarded an honorary degree.

Doctor Harris, a native of Berkeley County, received his pre-medical training at West Virginia University and was graduated from the two-year School of Medicine. He received his M. D. degree from Jefferson Medical College in Philadelphia and has practiced his specialty of surgery in Parkersburg since his discharge from the Medical Corps of the Army following service in World War I.

He served as a member of the University Board of Governors from 1945 until last June. In this capacity he had a major role in the planning and development of the Medical Center.

Doctor Shannon is recognized in the scientific field for his original research in kidney function, chemotherapy and malaria. He served as associate director of the National Institutes of Health for 15 years prior to his appointment as director in 1955.

### Doctor Hash Represents Medical Profession

Dr. John W. Hash of Charleston, president of the West Virginia State Medical Association, represented the approximately 1500 members of the Association at the ceremonies and was among the dignitaries seated on the speaker's platform who were introduced by President Stahr.

### Climax of Building Program

The dedication of the Teaching Hospital climaxed a building program which began with ground breaking on December 9, 1952. The Basic Sciences Building was completed and dedicated on October 5, 1957, and the Hospital began receiving patients in August of this year.

Construction and operation of the multi-million-dollar Medical Center is financed by a soft drinks tax enacted by the Legislature in 1951, which yields more than $3 million a year.

### Hospital Formally Accepted

The Teaching Hospital was formally accepted on behalf of the state and the University by Governor Underwood and President Stahr. The Governor expressed the appreciation of West Virginia citizens to all of those who contributed to the development of the Medical Center.

"I sincerely hope that, in years to come, this Center will be recognized nationally as a Center for research

against disease," Governor Underwood said. "It is just as important to succeed in finding a cure for cancer as it is to get a man to the moon."

President Stahr praised the work of the planners of the Medical Center and stated that "all West Virginians are to be commended for their foresightedness in the need of medical education and research."

### 'A Step Forward'

In his address, Doctor Shannon said that "the dedication of this Center symbolizes not only a major achievement of the state of West Virginia, but also a step forward in meeting a national need of great urgency."

He said that although federal aid was given the project, "the Medical Center was built primarily through funds provided by West Virginia residents. This giant progressive step should be the pride of every person in the state."

Doctor Shannon endorsed the location of the Medical Center in Morgantown. He said that in the past few years the trend has been to build medical centers away from large cities.

### 'Planners' of the Medical Center

Former Governor Okey L. Patteson also emphasized that he had "no regrets" about his decision to locate the Medical Center in Morgantown. The Legislature in 1951 placed the responsibility of selecting a site for the Center in the hands of the Governor, who, in turn, selected Morgantown after several months of study.

He said he believed that the passage of legislation which gave birth to the Medical Center was the "outstanding accomplishment during my service as governor. This is one of the most important days in the history of our state, and the benefit received from this medical center by the state will be appreciated for many years to come."

Former President Irvin Stewart expressed equal pride in being among those who were instrumental in the establishment of the Medical Center.

"Today we dedicate a dream," he said, "a dream that has become a tangible reality."

Doctor Stewart, who is now serving as professor of political science at the University, said "we were the planners of the Medical Center. Now, the planners turn the stage over to the actors. Justification of this structure depends on the use of it."

### Legislative Reunion

Many members of and candidates for the State Legislature were present at the ceremony, as were several of the candidates for Congress. They were invited to attend the morning program and also were guests of the University at a luncheon and at the West Virginia University-Richmond football game that afternoon.

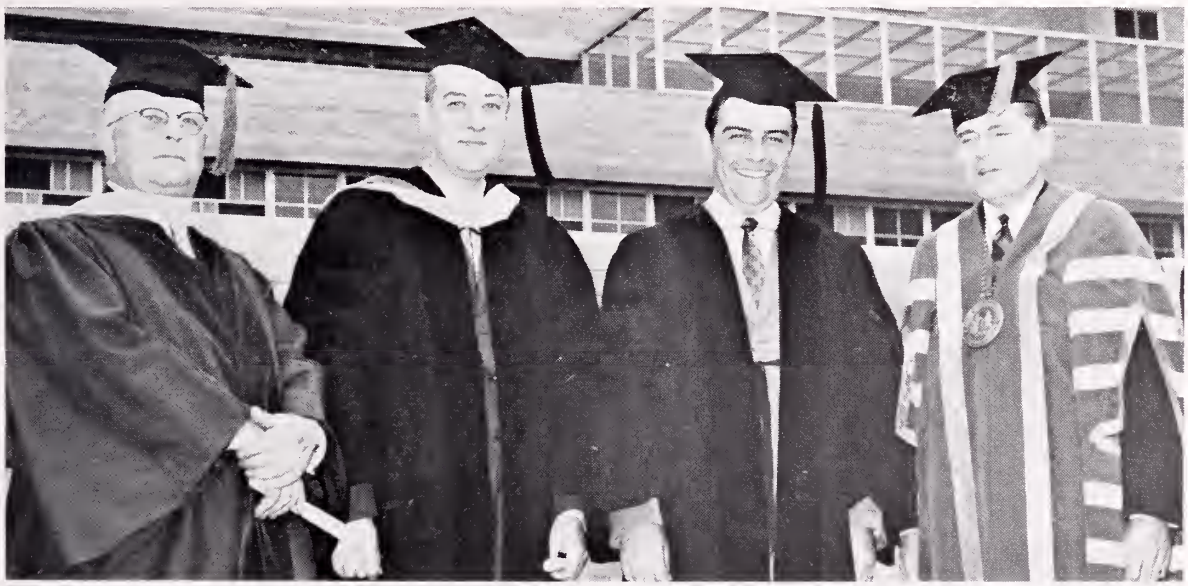
### Student Enrollment

More than 350 students are enrolled this year in the Schools of Medicine, Dentistry, Nursing and Pharmacy, all of which are housed under one roof at the Medical Center. University officials have indicated that enrollment will reach approximately 1,200 students when the Center is in full operation.

The first four-year class in the School of Medicine was enrolled in 1958 and 16 third-year students will in 1962 receive the first M. D. degrees ever awarded by the University. Forty-six students were enrolled in the first-year class this fall.

### Center Located on 145-Acre Tract

The Medical Center is located on a 145-acre tract approximately a mile from the main campus in the heart of Morgantown. Construction work on the Center began in 1952 and the 1,256-room Basic Sciences Building was completed in 1957.



**Dignitaries at the dedicatory ceremonies for the Teaching Hospital at the West Virginia University Medical Center are, left to right, Dr. Thomas L. Harris of Parkersburg and Dr. James A. Shannon, Director of the National Institutes of Health, each of whom received an honorary Doctor of Science degree; Governor Cecil H. Underwood; and University President Elvis J. Stahr, Jr.**

The 14-story, 2,156 room hospital, which will have a 522-bed capacity when in full operation, was completed earlier in the year and the first patients were admitted in August. The Hospital adjoins the Basic Sciences Building, and together they form one great structure with a total of 3,412 rooms.

### The Building Committee

A building committee composed of faculty members of the various schools in the Medical Center was appointed in 1951, and the membership has remained virtually intact since that date.

Dr. John M. Slack served as chairman and the other members of the committee were Drs. Edward J. Van Liere, R. F. Krause, M. L. Hobbs, J. C. Stickney, Clark K. Sleeth, T. W. Williams, J. J. Lawless and J. Ben Robinson.

The Teaching Hospital formed an impressive background for the speaker's platform at the dedicatory ceremonies, which was attended by more than 500 persons.

## Annual Interim Session of ACCP In Washington, Nov. 26-27

The Annual Interim Session of the American College of Chest Physicians will be held at the Shoreham Hotel in Washington, D. C., November 26-27, with the president, Dr. M. Jay Flipse of Miami, Florida, presiding.

A scientific program of exceptional interest has been arranged by a committee headed by Dr. Joseph W. Peabody, Jr., of Washington, D. C. Subjects to be discussed include symposia on congenital bronchopulmonary disorders, the role of steroid therapy in chest diseases, and current therapeutic issues.

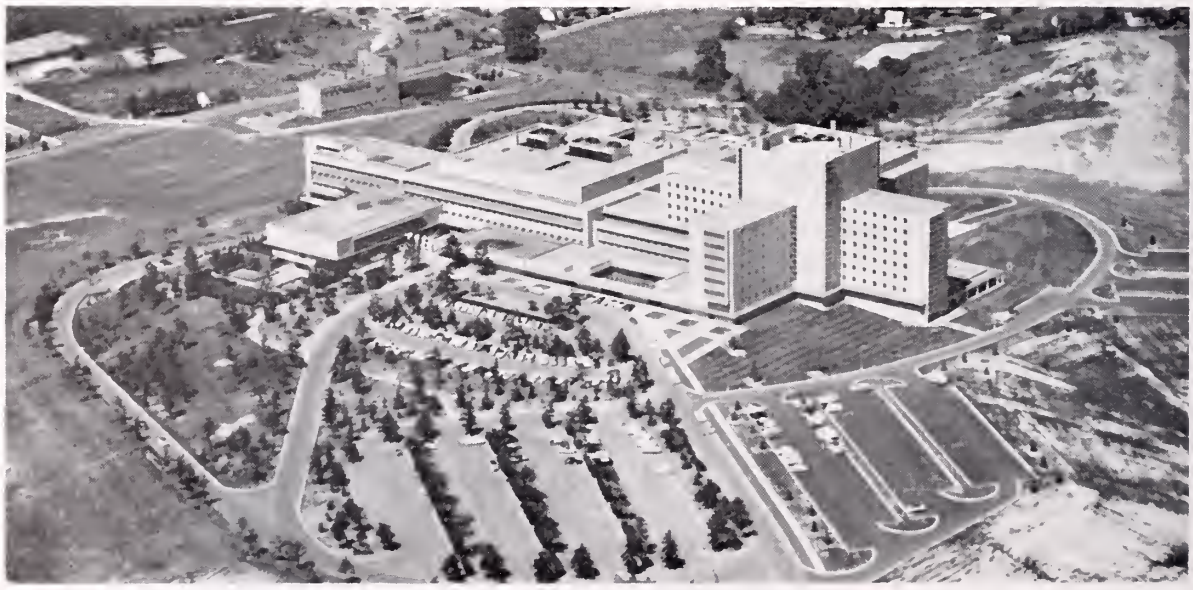
One of the highlights of the program will be the fireside conferences on Sunday evening, November 27. There will also be three round table luncheon discussions on both Saturday and Sunday, featuring addresses by prominent speakers on the various aspects of heart and lung disease.

## Dates Fixed for 7th Annual Series Of Bahamas Conferences

Dates for the Seventh Annual Series of Bahamas Conferences have been announced by the Executive Director, Mr. Irvin M. Wechsler, of Nassau. All of the conferences will be held in Nassau. The schedule follows:

| Conference | 1960-1961 |
|---|---|
| 10th Medical Conf. | Nov. 30-Dec. 10 |
| 3rd Surgical Conf. | Dec. 28-Jan. 7 |
| Conf. on Hypertension | Jan. 8-14 |
| 3rd Serendipity Conf. | Jan. 22-28 |
| 2nd Allergy Conf. | Feb. 9-15 |
| 11th Medical Conf. | Apr. 3-15 |
| Conf. on Internal Medicine | Apr. 30-May 6 |

Further information concerning the conferences may be obtained by writing to Mr. Wechsler, Box 1458, Nassau, Bahama.



An aerial view of the multi-million dollar Medical Center at West Virginia University. Construction work on the Center began in 1952 and one phase of the work ended with completion of the Basic Sciences Building in 1957. The Teaching Hospital was completed earlier this year and the first patients were admitted for treatment in August. There are 3,412 rooms in the Medical Center and the 14-story Teaching Hospital will have a 522-bed capacity when in full operation.

## New Association Members

Dr. Robert B. Cleary, 436 Division Street, South Charleston (Kanawha). Doctor Cleary, a native of Boston, Massachusetts, received his M. D. degree from Harvard Medical School in 1939. He interned and served a residency at Boston City Hospital and served as a Captain in the Medical Corps of the AUS, 1942-46. He formerly practiced his specialty of surgery in Boston and at Milledgeville, Georgia.

Dr. John M. Hartman, 501 Atlas Building, Charleston (Kanawha). Doctor Hartman was born in Charleston and was graduated from West Virginia University. He received his M. D. degree from the University of Maryland School of Medicine in 1953 and served an internship at the United States Naval Hospital in San Diego, California, 1953-56, during which time he served as a Lieutenant in the Medical Corps of the United States Navy. He served a residency at the Ohio State University Hospital in Columbus, 1956-59, and was a Fellow in cardiovascular research at that Hospital, 1959-60. His specialty is internal medicine.

Dr. Robert D. Hess. 145 West Main Street, Bridgeport (Harrison). Doctor Hess, a native of Bridgeport, attended the twe-year School of Medicine at West Virginia University and received his M. D. degree from the Medical College of Virginia in 1958. He interned at Charleston Memorial Hospital, 1958-59, and served a residency at that Hospital, 1959-60. He was licensed to practice in West Virginia in 1959.

Dr. George H. Pierson, Jr., Box 4072, Clendenin (Kanawha). Doctor Pierson was born in Charleston and was graduated from Washington and Lee University. He received his M. D. degree from Duke University School of Medicine in 1954, and interned at the Duke University Hospital, 1954-55. He served as a Captain in the Medical Corps of the United States Air Force, 1955-57, and was licensed to practice in West Virginia in 1958.

Dr. David J. Skewes, Coalwood (McDowell). Doctor Skewes, a native of Procterville, Ohio, was graduated from the University of Richmond and received his M. D. degree from the Medical College of Virginia in 1956. He interned at Johnston-Willis Hospital in Richmond, 1956-57, and then served for two years as a Captain in the Medical Corps of the United States Air Force. He was licensed to practice in West Virginia in 1959.

## AMEF Presents Awards of Merit To Two State Physicians

Two members of the West Virginia State Medical Association have been presented with awards of merit and citations by the American Medical Education Foundation.

Citations, signed by George F. Lull, M. D., president of the AMEF, were presented early in October to Charles B. Chapman, M. D., internist, Grace Hospital, Welch, and John E. Echols, M. D., surgeon of Richwoed, "in recognition of their work on behalf of medical education during 1959."

## Plans Completed for Eighth Annual Bluefield Sanitarium Seminar

The Eighth Annual Medical Seminar, sponsored by the Bluefield Sanitarium, the Stevens Clinic and the Clinch Valley Clinic, will be held in Bluefield on November 9. The one-day meeting will feature a scientific session in the afternoon and a banquet that evening.

The scientific session will be held in the Bluefield High School auditorium, beginning at 3 P. M., and the banquet, which will be preceded by a social hour, will be held at the Bluefield Country Club.

The first part of the afternoon program will feature a "Symposium on Soft Coal Miner's Pneumoconiosis." The speakers will be Mr. David Kennedy of Beckley, attorney and councilor for the United Mine Workers of America, and Mr. William Rice, attorney of Harlan, Kentucky.

Dr. Henry F. Warden, Jr., a member of the staff at the Bluefield Sanitarium, will present several case reports.

Following the case reports, two prominent guest speakers will participate in a "Discussion of the Problem from the Medical and Medico-Legal and Radiological Aspects." The speakers will be Arthur J. Vorwald, M. D., Professor and Chairman of the Department of Industrial Medicine and Hygiene, Wayne State University College of Medicine, Detroit, Michigan, and Eugene P. Pendergrass, M. D., Professor of Radiology, University of Pennsylvania School of Medicine, Philadelphia, and immediate past president of the American Cancer Society.

Mr. Jim Comstock of Richwood, editor and publisher of *The Hillbilly*, will be the speaker at the banquet. His subject will be "The Life and Hard Times of a Hillbilly Editor."

## Dr. Samuel C. Dotson Joins Staff At WVU Health Service

Dr. Samuel C. Dotson, Jr., of Cameron, Marshall County, has accepted appointment as a member of the medical staff at the West Virginia University Student Health Service. The appointment was announced by University President Elvis J. Stahr, Jr.

A native of Richwood, Doctor Dotson received a B. S. degree from the two-year School of Medicine at West Virginia University in 1937, and an M. D. degree from Northwestern University Medical School in 1939. He interned at Ohio Valley General Hospital in Wheeling, 1939-40, and was licensed to practice in West Virginia in 1940.

Doctor Dotson is a member of the Marshall County Medical Society, the West Virginia State Medical Association and the American Medical Association.

### Manners

Manners are the happy ways of doing things . . . if they are superficial, so are the dewdrops, which give such a depth to the morning meadow.—Ralph Waldo Emerson.

## Many Problems Aired at 13th Annual Rural Health Conference

Inclement weather failed to hold down attendance at the 13th Annual Rural Health Conference which was held at Jackson's Mill on Thursday, October 6. Official attendance was 246, or 12 less than the record 258 persons who attended the 1958 meeting.

The keynote speaker for the one-day meeting was Dr. W. Wyan Washburn of Boiling Springs, North Carolina, a member of the Council on Rural Health of the American Medical Association. It was necessary for Doctor Washburn to leave the conference immediately following his address in order to travel to Atlanta, Georgia, where he presided at the opening of a regional rural health meeting the next morning.

The West Virginia State Medical Association sponsors the conference annually under the auspices of its Rural Health Committee, with the full cooperation of the West Virginia Home Demonstration Council, the West Virginia Farm Bureau, the State Department of Health, the West Virginia Congress of Agriculture, and the Agricultural Extension Division of West Virginia University.

Dr. Earl L. Fisher of Gassaway, center, presiding officer at the 13th Annual Rural Health Conference, is shown with Dr. Stanley H. Martin, President of West Virginia Wesleyan College, left, and Dr. W. Wyan Washburn of Boiling Springs, North Carolina, the keynote speaker.

### Doctor Fisher Presides at Conference

The meeting was called to order at 10 A. M. by Dr. Earl L. Fisher of Gassaway, the presiding officer. He is immediate past chairman of the Rural Health Committee of the State Medical Association.

The invocation was given by Dr. Stanley Martin of Buckhannon, president of West Virginia Wesleyan College.

### Keynote Address

The subject of Doctor Washburn's keynote address was "Health is Wealth." Elaborating on his subject, he said that a man's health is likely to set the pattern for his success or failure in business.

"The longer you live," he said, "the more you are likely to earn. If you die young, you cannot enjoy the fruits of your earnings."

Doctor Washburn said, "saying 'Health is Wealth' is a positive approach. From another point of view, disease is poverty; sickness is financial ruin, bankruptcy, privation and want."

He described the sick and impoverished people of the underdeveloped countries of Africa and the Middle East which he visited in 1959. "Half of the population in that area of the world is unwell. They are beset with leprosy, malaria, tropical infections of the bowel, lungs and skin."

The speaker said these people cannot work and, therefore, cannot produce wealth. "If we could rid them of their disease and lighten their minds with the knowledge of the atomic and space age," he said, "they would be able to take their place with the rest of the world."

### Life Expectancy

Doctor Washburn called attention to the fact that a baby born in the United States today can expect to live an average of 30 years longer than the baby who was born 60 years ago. He attributed this to the modern advances in the field of medicine and science.

"Survival is still the first law of life," he said, "and as John Ruskin contended, 'There is no wealth but life.'"

### Cost of Medical Care

Doctor Washburn said illness hits a person's pocketbook in two ways. "In the first place," he said, "you lose the money you could be earning and, secondly, you have to pay. You pay the hospital, the druggist and your own physician."

He said even the cost of the common cold can be devastating. "A sore throat may cost as much as $20 to $40; a heart attack can easily run to $2,000. Mental illness may amount to $1,000 per month and round-the-clock nursing care is $40 to $50 per day.

He said these prices sound "terrible," but actually are bad only by comparison. "You work 23 minutes a day for all the costs of being sick," he said, "then you work 2 hours and 20 minutes just to pay your federal taxes."

He pointed out that the average family in the country spends about $300 per year for all medical expenses, including drugs. He added that in West Virginia the figure is possibly a little less.

"Again," he said, "things cost too much only by comparison. The same family spends almost twice that amount for tobacco and alcohol."

### Support for State Department of Health

Doctor Washburn praised the work of the State Department of Health and urged that participants at the conference urge their representatives in the state legislature to increase the annual appropriation to this department so that additional personnel may be obtained and new services added.

"You have a health department in this state that you can be proud of," he said, "but your per capita expenditures for all phases of public health activities, both local and statewide, amount to about the cost of

a carton of cigarettes, a little less than $2 per person. For less than an office call to your family physician you are depending on your health department to protect the public from disease and harm."

### 'Quacks Still at Work'

Doctor Washburn said that contrary to common belief, "modern quacks continue to milk millions of dollars from the public for medicines and nostrums they do not need."

He said that radio and TV "medicine shows" far surpass anything seen in grandpa's day as they peddle "anything from alfalfa to watercress, honey and vinegar, and so-called food supplements."

He said most of these quacks pose as experts. "They have a 'secret' and promise a quick cure for dandruff or cancer. They claim to do it cheaper, and they always criticize the American Medical Association."

### Morning Workshop Sessions

Following Doctor Washburn's address, the remainder of the morning session was devoted to consideration by four workshops of rural health problems in West Virginia. The following topics were discussed at the workshops:

(1) Cost and Availability of Medical Care in Rural Areas; (2) Mental Attitudes Toward Health; (3) Health Mobilization in Rural Areas; and (4) Conservation and Health.

Discussion continued until noon when those attending the conference adjourned to the Mount Vernon Dining Hall for lunch as guests of the State Medical Association.

### Address by Dr. John W. Hash

Dr. John W. Hash of Charleston, president of the West Virginia State Medical Association, was introduced by Doctor Fisher and delivered a short address of welcome at the opening of the afternoon session.

Doctor Hash stated that the conferences at Jackson's Mill are looked upon with much pride by the members of the State Medical Association.

"These annual meetings," he said, "provide an ideal atmosphere for the interchange of ideas. We all know that health and education are of prime importance to the future of our great country."

"Our Association looks forward to perpetuation of these rural health conferences," he said, "and we hope that all of the organizations represented here today will continue to give us their wholehearted support."

### Spokesmen for Morning Discussion Groups

Following Doctor Hash's address, the remainder of the afternoon program was devoted to a summary of the material presented before the three discussion groups in the morning.

Dr. J. C. Huffman of Buckhannon, immediate past president of the State Medical Association, served as spokesman for the discussion group on "Cost and Availability of Medical Care in Rural Areas."

He said his group devoted a great deal of time to a discussion of the rising costs of medical care throughout the country, including hospitalization, cost of drugs, health insurance premiums and fees of physicians.

He said that the cost of hospital care has increased 166 per cent in the past 10 years, compared to a 122 per cent increase in the cost of drugs, 143 per cent increase in health insurance premiums, and 67 per cent increase in physician's fees.

Doctor Huffman pointed out some of the reasons behind the high cost of hospital care. "There has been a significant increase in wages for hospital personnel," he said, "and it is interesting to note that it costs a hospital more than $500 a year to train one nurse."

He said patients can help lower the cost of medical care in the following way: (1) Discuss fees with the

**The morning session at the Rural Health Conference was devoted to workshops dealing with problems confronting persons living in the rural areas. In the picture at the left, Dr. J. C. Huffman of Buckhannon answers a question from the audience. Others shown in the picture are, left to right, Dr. George T. Hoylman of Gassaway, Dr. Roy Bird Cook of Charleston, Ward Stone and Miss Audrey E. Windemuth, both of Morgantown.**

**In the other picture, Dr. Clark K. Sleeth of Morgantown served as spokesman for one of the morning workship groups. The other spokesmen were, left to right, Dr. J. C. Huffman of Buckhannon, Samuel J. Hawkins of Charleston, Dr. Earl L. Fisher of Gassaway, and Dr. George F. Evans of Clarksburg.**

physicians prior to treatment; (2) select a family physician before illness strikes so that he can serve as a guide as to the type of specialized medical treatment and hospitalization that might be needed; and (3) obtain adequate health insurance against catastrophic illness. He warned against abuse of health insurance inasmuch as such abuse is reflected in the amount of the insurance premium.

"We all agreed," Doctor Huffman said, "that the best way to lower medical care costs is to fight inflation. The cost of everything we buy has increased in the past 20 years and medical care costs have gone up proportionately."

### Availability of Medical Care

Doctor Huffman said recent surveys indicate that there are 87 physicians per 100,000 population in West Virginia, as compared to the national average of 126 per 100,000.

"These surveys show," he said, "that by 1970 the ratio in West Virginia will be 75 per 100,000. We hope, of course, that our new four-year medical school at Morgantown will prove those figures wrong."

Doctor Huffman said citizens in every community can help solve this problem by encouraging young men and women to enter the field of medicine. He also said it is "up to all of us to urge the graduates of our medical school to locate for practice in West Virginia."

### Mental Attitudes Toward Health

Dr. George F. Evans of Clarksburg, a past president of the State Medical Association, served as spokesman for the discussion group on "Mental Attitudes Toward Health."

He said it was the consensus of his group that "the focal point of the development of good health in children, both physically and mentally, is in the home It is the responsibility of the parents to instill good attitudes toward health in children at an early age."

He said the following individuals and agencies offer the best source of guidance to troubled adults and children: (1) Clergymen, (2) the family physician, (3) psychiatrists and psychologists, (4) mental health clinics, and (5) self-help.

### Conservation and Health

Dr. Clark K. Sleeth of Morgantown, Assistant to the Dean, West Virginia University School of Medicine, was the spokesman for the group discussion on "Conservation and Health."

He said one of the most important points brought out in his discussion group was that people in both urban and rural areas fail to take advantage of various measures at their disposal in the field of preventive medicine.

"We now have a vaccine to protect us against polio," he said, "but children and adults still are afflicted by this crippling disease. Many of our citizens fail to get their shots, even if offered free."

Doctor Sleeth said many individuals do not know where to go for treatment in the fields of preventive medicine or rehabilitation.

**Dr. Guy R. Post of Fairmont, left, talks with Dr. Roy Bird Cook of Charleston during a break in the proceedings at the Rural Health Conference.**

"In rural communities that do not have health departments," he said, "it would be a good project for an organization such as the Farm Women's Club to set up a center where individuals could obtain information concerning health problems."

### Health Mobilization in Rural Areas

Samuel J. Hawkins, Program Consultant for Health Mobilization, State Department of Health, was the spokesman for the discussion group on "Health Mobilization in Rural Areas."

He emphasized from the beginning that it is "imperative that we be prepared" in the event of an enemy attack. He also said it is just as important that we be prepared for natural disasters such as hurricanes, tornados and cyclones that may lay desolate a section of our country.

"Individual preparedness is essential," he said. "If the enemy strikes, we may not even have the help of our next door neighbor. That is why we must have shelters in our homes or at least know where to find a public shelter. Likewise, we must be sure that one member of each family is trained in first aid; and that necessary supplies to last for a specified time be on hand."

Mr. Hawkins recommended that courses in civil defense be made a part of the curriculum in all schools from the first grade through college.

### Remarks by Doctor Fisher

In his concluding remarks, Doctor Fisher said it was his belief that the completion of the four-year School of Medicine at West Virginia University will mean an uplift in the quality of medical care in this state.

"In years past," he said, "when patients needed special treatment which could be provided only at large medical centers and universities, physicians had no alternative but to send them to clinics and hospitals outside the state. Now we have a medical center in West Virginia where we can send patients with assurance that they will receive specialized care equal to that provided at any institution in the country."

## 14th Annual AMA Clinical Meeting In Washington, Nov. 28-Dec. 1

More than five thousand physicians are expected to attend the 14th annual Clinical Meeting of the American Medical Association which will be held in Washington, D. C., November 28-December 1.

Headquarters for the meeting will be the Sheraton-Park Hotel, where the House of Delegates will meet throughout the week. The scientific program, including lectures, symposia, medical motion pictures, color television and scientific and technical exhibits will be held at the District of Columbia National Guard Armory.

### State Delegates to Attend Meeting

Dr. Charles A. Hoffman of Huntington and Dr. Frank J. Holroyd of Princeton are the official delegates from the West Virginia State Medical Association and will attend all sessions of the AMA House of Delegates. The alternate delegates from West Virginia are Dr. J. C. Huffman of Buckhannon and Dr. Thomas G. Reed of Charleston.

### Scientific Program

The meeting will offer a well-rounded, stimulating scientific program designed to interest both family physicians and specialists. The symposia, presentations and discussions will stress the theme, "New Developments in Old Diseases and Old Developments in New Diseases."

Participants will include proponents of both sides where different views exist on the management of a disease or medical condition.

The patient's side will also be heard on one symposium. Clarence B. Randall, an industrialist and special assistant to President Eisenhower, will talk on coronary disease from the patient's viewpoint. Other participants on this panel will include:

Dr. A. Carlton Ernstene, Cleveland, Ohio, Moderator; Dr. Thomas W. Mattingly, Washington, D. C.; Dr. Donald S. Fredrickson, Bethesda, Maryland; Dr. Victor A. McKusick, Baltimore, Maryland; and Dr. Eugene A. Stead, Jr., Durham, North Carolina.

The problem of management of nodules will be discussed by three panels concerned with breast nodules, solitary pulmonary nodule, and nodules of the neck. Another panel will discuss recent advances in the use of antibiotics and steroids, and additional symposia will cover areas in obstetrics and gynecology, pediatrics, edema, cirrhosis and liver diseases, renal problems, osteoporosis, thyrotoxicosis, eye problems, orthopedic surgery and trauma, clinical nutrition and bronchopulmonic disease.

Prominent physicians and research scientists from throughout the nation will conduct the scientific program, and the timetable of discussions has been arranged so that physicians may attend the maximum number of sessions and participate in discussions in the particular fields in which they are most interested.

Medical motion pictures will be shown at the Armory as well as closed colored television showings originating in Georgetown University Hospital. Six one-hour TV presentations will be devoted to dermatology, pediatrics, emergency treatment of major injuries, newer methods of surgical treatment of peptic ulcer, orthopedics and pathology.

### AMA to Honor General Snyder

Major General Howard M. Snyder (MC) USA, personal physician to President Eisenhower, will be the guest of honor at the AMA House of Delegates dinner on November 28.

President Eisenhower has been invited and is expected to attend if his official schedule permits.

General Snyder, who has been with President Eisenhower since the early 1940's, was appointed personal physician to the President in January, 1953, when the President was inaugurated for his first term in the White House.

Graduated from Jefferson Medical College, Philadelphia, in 1905, and the Army Medical School, Washington, D. C., in 1908, General Snyder, now 79, served continuously in the Army Medical Corps until he retired June 30, 1948. He was recalled to active duty on January 1, 1951, and assigned to Supreme Headquarters, Allied Powers in Europe, during the period President Eisenhower was Supreme Commander.

After another short period of inactive duty during Eisenhower's campaign for President in 1952, General Snyder returned to active duty to become the President's personal physician.

### Medical Aspects of Sports

The Second National Conference on the Medical Aspects of Sports will be held at the Statler-Hilton Hotel on November 27, the day preceding the formal opening of the meeting.

The Conference will be held under the auspices of the AMA Committee on the Medical Aspects of Sports and will feature lectures and panel discussions on the training and conditioning of the athlete, prevention and treatment of injury, and functions of the team physicians.

A luncheon meeting will feature as speaker a prominent figure in the field of sports, and the evening session will include movies taken during the Olympic games in Rome.

### 'General Practitioner of the Year'

The "General Practitioner of the Year" will be named by the House of Delegates at its first session on November 28. Dr. Chesley M. Martin of Elgin, Oklahoma, was named as the recipient of the award in 1959, which is given annually to an outstanding American physician for his medical and civic contributions to his community.

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## A Positive Approach to Rehabilitation

The phrase "easing the burden of chronic illness or handicap" is seldom heard any more. Rather there is the more positive approach of restoring and rehabilitating. There can be little doubt that rehabilitation offers the chance to participate in a grand design of reconstruction for both laymen and professional; further that it is personally one of the more inspiring and rewarding contributions anyone can make.—W. Scott Allan in Journal, Maine Medical Association.

## Dr. Carl E. Johnson New President Of Medical School Alumni Assn.

Dr. Carl E. Johnson of Morgantown was elected president of the Alumni Association of the West Virginia University School of Medicine at a banquet meeting held at the Hotel Morgan in Morgantown on October 8, 1960. He succeeds Dr. John W. Hash of Charleston.

Dr. C. R. Davisson of Weston was elected vice president and Dr. S. Elizabeth McFetridge of Shepherdstown, member of the executive council. Dr. Clark K. Sleeth of Morgantown continues as secretary-treasurer.

The hold-over members of the executive council are Drs. Theresa O. Snaith of Weston, L. E. Neal of Clarksburg and Robert U. Drinkard of Wheeling. The retiring president, Doctor Hash, will serve as chairman of the council.

During the banquet, a beautiful silver epergne was presented to Dr. and Mrs. Van Liere by the members of the Alumni Association of the School of Medicine.

It was announced during the meeting that there are now more than 1900 graduates of the WVU School of Medicine.

Dr. Sergio S. Pena of New York City was one of the former graduates of the WVU School of Medicine who was present at the dedication of the hospital at the new Medical Center in Morgantown on October 8. He was the sole representative of the class of 1923 who attended the banquet at the Hotel Morgan.

In his remarks during the affair, Doctor Pena praised the state of West Virginia for constructing such a modern Medical Center and Hospital. He expressed regret that none of his classmates were present, and asked to be remembered to all members of the class of '23.

Doctor Pena is engaged in the practice of his specialty of cardiovascular diseases, with offices at 687 Prospect Avenue, The Bronx, New York City.

## Dr. N. J. Eastman ACOG President Elect

Dr. Nicholson J. Eastman of Baltimore has been named president elect of the American College of Obstetricians and Gynecologists. He fills the vacancy caused by the death last spring of the president elect, Herbert E. Schmitz, M. D., of Loyola University, Chicago.

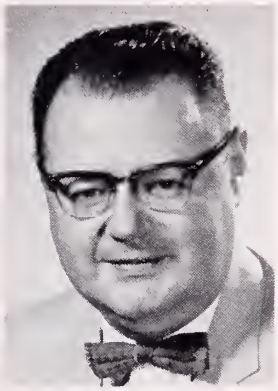
Doctor Eastman has been professor of obstetrics at Johns Hopkins University and obstetrician-in-charge for the past 25 years. He retired from active practice and from his teaching posts and plans to devote much time to the office to which he has been named. He will be formally elected president at the ACOG Tenth Anniversary meeting in Bal Harbour, Florida in April, 1961.

The First Annual Postgraduate Meeting of the Central West Virginia Medical Society was held at the Buckhannon Country Club in Buckhannon on September 22. Shown at the speaker's table during the banquet are, left to right, Dr. John E. Echols of Richwood, president of the Society; Mrs. Echols; Dr. Bernard Zimmermann of Morgantown, the guest speaker; Dr. John W. Hash of Charleston, president of the State Medical Association; Mrs. Hash; and Dr. Robert L. Chamberlain, chairman of the program committee.

In the bottom picture, left to right, Dr. Clark K. Sleeth of Morgantown, Doctor Hash, Doctor Zimmermann, Doctor Chamberlain, Dr. J. C. Huffman of Buckhannon, and Dr. Edmund B. Flink of Morgantown. Drs. Flink and Zimmermann were the guest speakers on the scientific program.

## Dr. Merle S. Scherr on Allergy Programs in Argentina

Dr. Merle S. Scherr, allergist of Charleston, will travel to Argentina later this month to appear as a guest speaker before several conferences on allergy which will be held in Buenos Aires and Rosario. The meetings are part of a year-long celebration of the 150th anniversary of Argentine independence.



Merle S. Scherr, M. D.

Doctor Scherr will first present a paper at a conference in Rosario, November 28-30, which will be under the auspices of the Postgraduate Department of the Rosario Medical School, National University of Litoral.

He will present another paper at a meeting in Buenos Aires, December 1-3, which will be sponsored by the Department of Hygiene and Social Medicine, Buenos Aires Medical School, Buenos Aires National University.

In addition to his participation on the programs sponsored by the medical schools, Doctor Scherr will be one of the speakers before the First Inter-American Conference on Allergy which will be held during the week in Rosario. The subject of his paper on that occasion will be "Management and Rehabilitation of the Bronchial Asthma Patient."

He is also scheduled to appear as a speaker before the Argentina Allergy Society, at which time the film, "The Hidden Tear," will be shown. The film documents the development of an unique training and rehabilitation program for asthmatic children in the Charleston area. Doctor Scherr originated the program and now serves as its medical advisor.

## Medical Meetings, 1960-61

The following is a partial list of national, state and district medical meetings scheduled for 1960-61:

**1960**

Nov. 28-Dec. 3—AMA Clinical Meeting, Washington, D. C.
Dec. 6-8—Southern Surgical Assn., Boca Raton, Fla.

**1961**

Jan. 9-11—Medical Licensing Board, Charleston.
Mar. 6-8—New Orleans Grad. Med. Assembly, New Orleans.
Apr. 17-20—AAGP, Miami Beach, Florida.
Apr. 21-22—W. Va. St. Soc. Med. Technologists, Wheeling.
May 8-12—Am. Coll. Physicians, Miami Beach, Fla.
May 22-25—Am. Urological Assn., Los Angeles.
June 22-26—ACCP, Hotel Commodore, New York City.
June 26-30—Annual Meeting, AMA, New York City.
**Aug. 24-26—W. Va. St. Med. Assn., The Greenbrier, White Sulphur Springs.**
Oct. 2-6—Am. Coll. Surgeons, Chicago.
Nov. 28-Dec. 1—AMA Clinical Meeting, Denver.

## Mrs. Glenice Cather Reelected Head Of W. Va. Nurses Association

Mrs. Glenice Cather of Grafton was reelected president of the West Virginia Nurses Association at the 53rd annual meeting held at the Shenandoah Hotel in Martinsburg, October 12-14. Other officers were elected as follows:

Sister Mary Helen of Huntington, first vice president; Miss Dorothy Crawford of St. Albans, second vice president; and Miss Kathryn Henderson of Charleston, reelected secretary.

Miss Marian Hutton of Huttonsville was elected chairman of the Board of Directors. Other members are Mrs. Mildred M. Ridgeley, Fairmont, Mrs. Genevieve F. Shaw of Philippi, Sister Rose Anthony of Wheeling, and Miss Alberta Rosier of Fairmont.

Miss Juliann Ritter is the executive secretary of the organization.

Miss Elinor McGinnis of Clarksburg was elected president of the West Virginia Student Nurses Association, and Miss Helen Biesczad of Clarksburg and Miss Rosemary Grow of Clarksburg were named vice president and secretary-treasurer, respectively.

The Association voted to hold its 1961 meeting in Clarksburg, October 18-20.

## MLB Licenses 26 Physicians as Result Of October Examination

Announcement has been made by the Medical Licensing Board that 26 physicians have been licensed by reciprocity to practice medicine in West Virginia as the result of examinations held in Charleston on October 3, 1960. The list follows:

Anderson, William Evan, Morgantown
Baker, Louis Reed, Morgantown
Blackman, David, Fairmont
Caplen, Clifford William, Fairmont
Christie, William Edward, Jr., Elkins
Duff, Wirt Rexford, Montgomery

Fernandez, Jose Ramon, Fairmont
Flink, Edmund Berney, Morgantown
Fugo, Nicholas William, Morgantown
Gallagher, James Vincent, III, Fairmont
Grigsby, William Paul, Huntington
Hiatt, Daniel Deane, Man
Hofreuter, Donald Henry, Wheeling
Hofreuter, Virginia Dulany, Wheeling

Jones, Richard Elwood, Morgantown
Klingberg, William Gene, Morgantown
Korfhage, Quentin, Gallipolis, Ohio
Mahan, Thomas Kent, Beckley
Moran, Walter Harrison, Jr., Morgantown
Rice, Elmer Walter, Martinsburg

Schurter, Lonis Leon, Romney
Straub, Russell Elwood, Parsons
Stuart, Edward George, Morgantown
Thompson, Elvis Robert, Williamson
Thompson, Marguerite E. Tanner, Williamson
Warden, Herbert Edgar, Morgantown

The winter meeting of the Medical Licensing Board will be held in Charleston, January 9-11, 1961, for the purpose of examining applicants for licensure in West Virginia.

## Citations Awarded for Meritorious Service to the Handicapped

An open house marked the observance of the fifth anniversary of the West Virginia Rehabilitation Center at Institute. Ceremonies arranged in connection with the observance on Sunday afternoon, October 16, featured an address by Dr. Thomas L. Harris of Parkersburg, past president of the West Virginia State Medical Association and member for several years of the West Virginia University Board of Governors. Doctor Harris currently is serving as chairman of the state advisory council to the Division of Vocational Rehabilitation.

### Citations for Meritorious Service

Presentation of citations for meritorious service to handicapped persons were made to Miles C. Stanley of Dunbar, president of the West Virginia Labor Federation, AFL-CIO, and Charles Lively of Charleston, executive secretary of the West Virginia State Medical Association. The awards were presented on behalf of the President's Committee on Employment of the Physically Handicapped.

### Division First in Rehabilitation Work

An award was also presented by Secretary of State Joe F. Burdette to the Division in recognition of its first place standing in the nation during the fiscal year 1959-60.

F. Ray Power, Director of Vocational Rehabilitation said that placing first in the nation in rehabilitation work climaxed a 12-year period in which West Virginia had ranked near the top in rehabilitation programs. He also said that the record shows that 3,023 disabled persons were restored to jobs during the past fiscal year. This is an average of 154 rehabilitations per 100,000 population.

A request has been made by the Division for the sum of $935,000 for expansion plans during the fiscal year 1961-62, which would include funds for the construction of a dormitory and a sheltered workshop. The remainder of the costs of the expansion program planned for the Center will be derived from the current operating budget.

Mr. Power explained that the proposed dormitory would increase the Division's facility at Institute to about 250 severely disabled clients. The sheltered workshop will provide jobs for those too severely handicapped for employment in competitive industry.

## ACCP Prize Essay Contest

The American College of Chest Physicians is offering free cash awards to winners of the 1961 prize essay contest. The first prize is $500; second, $300; and third, $200. Each winner will also receive a certificate.

The contest is open to undergraduate medical students throughout the world. Essays may be written on any phase of the diagnosis and treatment of chest diseases, either cardiovascular or pulmonary.

The contest closes on April 1, 1961. Application blanks and further information may be obtained by writing the American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

## Huntington Clinical Foundation Establishes Loan Fund

The Huntington Clinical Foundation has announced the inauguration of a loan fund program for medical students. Loans of up to $1,000 per year are available to third and fourth-year medical students who are citizens of West Virginia, or of a contiguous state and living within 200 miles of Huntington, or who attend the West Virginia University School of Medicine.

These loans are to be secured by notes, and recipients must agree to begin repayment two years following graduation from medical school. Instead of paying interest, each student must also agree to serve a one-year internship at either St. Mary's Hospital or Cabell-Huntington Hospital.

The present loan program was established this year. The Foundation itself was organized in 1947 by the terms of the will of the late Rufus Switzer, prominent attorney and former mayor of Huntington. Its stated objectives are to build better health in the community and to further medical education.

Amos A. Bolen, attorney of Huntington, is president of the Foundation, and the following physicians are members of the board of trustees: Drs. Ray M. Bobbitt, Francis L. Coffey, Lawrence B. Gang and Walter E. Vest.

Students interested in applying for loans may obtain additional information by writing to Dr. Lawrence B. Gang, Loan Committee Chairman, 1016 Sixth Avenue, Huntington.

## Dr. Hu C. Myers Elected President Of W. Va. Division, ACS

Dr. Hu C. Myers of Philippi was elected president of the West Virginia Division of the American Cancer Society at the annual meeting held at Mont Chateau near Morgantown, on October 15. Dr. Robert J. Johnson of Morgantown was named vice president, and Mr. J. Ross Hunter, Jr., of Charleston, and Mr. Paul Davidson, also of Charleston, were reelected secretary and treasurer, respectively.

Mr. Ralph G. Beveridge of Charleston continues as executive director.

The retiring president, Dr. Chauncey B. Wright of Huntington presided at the meeting, which was attended by more than 100 delegates from the state's 55 units.

During the meeting, awards were presented to Major General William E. Blake of Charleston and Lt. Col. C. E. Galaspie of Beckley for the part played by the West Virginia National Guard in "Operation Cancer Alert." Mr. K. Douglas Bowers of Beckley, 1960 state crusade chairman, also received an award for outstanding activities in connection with the Crusade.

The following were named as members-at-large of the executive committee: N. H. Dyer, M. D., Charleston; Mrs. D. N. Thomas, Weirton; Harry Cooper, M. D., Beckley; and Chauncey B. Wright, M. D., Huntington.

The new president, Dr. Hu C. Myers, was named professional delegate member to the National Society.

## AAMC Sponsors Foreign Fellowship Program for Students

The Association of American Medical Colleges is accepting applications from third and fourth year medical students who wish to spend three months next summer studying medicine in remote areas of the world.

Dr. Ward Darley, executive director of the AAMC, said that grants totaling approximately $50,000 were made last summer to 29 students under the program. The awards are made from a $180,000 fund provided by Smith Kline & French Laboratories of Philadelphia.

Known as the Smith Kline & French Foreign Fellowships, the program enables students to benefit from unusual clinical experiences at outpost facilities in greatly differing societies and cultures.

It is anticipated that about 30 Fellows will be selected in 1961. Applications for the grants are available through medical school deans and must be submitted to the AAMC by December 31, 1960.

The fellowships provide money for travel costs and living expenses during the three-month period. During the first year grants ranged from $1,000 to $3,000.

Last summer students studied in such places as Bolivia, Republic of the Congo, Ghana, Southern Rhodesia, Java, Thailand and India. Seventeen of the first-year Fellows studied at church supported mission hospitals. The remaining 12 were stationed at government, university and other hospitals and clinics.

## Dr. Ernst Jokl Returns to Charleston For Lecture on Nov. 10

Dr. Ernst Jokl, Professor of Anatomy and Physiology at the University of Kentucky, Lexington, will be the guest speaker at a meeting at the United Fuel Auditorium in Charleston on Thursday evening, November 10, at eight o'clock. His subject will be "Exercise and the Heart."

The meeting will be held under the auspices of the Lawrence Frankel Foundation of Charleston.

Doctor Jokl is the author of the chapter on the subject of "Exercise and the Heart" in the Encyclopedia of Cardiology, and he led the symposium for the College of Cardiology on the same subject.

Due to limited seating capacity, admission to the lecture will be by invitation. Interested parties may obtain invitations by contacting the Lawrence Frankel Institute, Inc., 106 Brooks Street, Charleston, phone DIckens 4-2397.

### Rehabilitation Defined

Rehabilitation is variously defined, but in general it is a planned attempt by use of all available means to restore or improve the health, usefulness, and happiness of those who have suffered injury or who are recovering from disease. All medical treatment has basically no other aim. Rehabilitation principles apply to all forms of medical and surgical disability or loss of physical and psychologic function resulting from prolonged illness.—Odon J. von Werssowetz, M. D., in Texas St. Journal of Medicine.

## Four West Virginia Surgeons Inducted As Fellows of the ACS

Four West Virginia surgeons were among the 1,175 inducted as new Fellows of the American College of Surgeons at ceremonies on October 14, closing the annual five-day Clinical Congress of the organization in San Francisco. The West Virginia list follows:

Drs. Jules F. Langlet, Charles Town; Robert A. Barnett, Huntington; Robert W. McCoy, Jr., Keyser; and Carl A. Liebig, Petersburg.

The American College of Surgeons was founded in 1913 "to establish standards of competency and character for specialists in surgery." The organization has grown from a founding group of 450 to a total membership of approximately 24,000.

Fellowship, entitling the recipient to the designation, "F.A.C.S." following his name, is awarded to physicians who fulfill comprehensive requirements for acceptable medical education and advanced training as specialists in one or another of the branches of surgery, and who give evidence of good moral character and ethical practice.

## 'Reach to Recovery Foundation' Organized in Charleston

A Charleston Chapter of the "Reach to Recovery Foundation" will be organized at meetings to be held in that city on Thursday, November 3. The first meeting will be at Charleston Memorial Hospital at four o'clock in the afternoon, and the second at the Charleston General Hospital Nurses' Home that evening at eight o'clock.

Mrs. Terese Lasser of New York City, founder of the nationwide program, and an associate, will attend both meetings. The voluntary non-profit organization was established in 1953 from funds made available by J. K. Lasser.

Problems concerned with a program of educational service—psychological, physical and cosmetic—for women who have had radical breast surgery will be discussed.

A cordial invitation has been extended to all interested physicians to attend the organization meeting. There is no registration fee and there will be no solicitation of funds.

Further information concerning the meeting may be obtained by contacting Mrs. Sidney M. Kleeman, Chairman, 910 Edgewood Drive, Charleston.

### Medrol and Neo-Medrol Drops Withdrawn

The Upjohn Company has withdrawn Medrol Eye-Ear Drops and Neo-Medrol Eye-Ear Drops because they at times produce ocular inflammatory conditions. This appears to be due to the vehicle and not to the Medrol or Neomycin content. They urge recall from patients now receiving them. Experimentation is being carried on to determine whether another vehicle can be used that will not produce chemical irritation.

## Frank E. Bunts Educational Institute Sponsors Oph. PG Course

A Postgraduate Continuation Course in Ophthalmology will be presented in Cleveland, Ohio, December 7-8, by the Frank E. Bunts Educational Institute, which is affiliated with the Cleveland Clinic Foundation.

The course will be presented by staff members of the Cleveland Clinic Foundation, assisted by several guest speakers. A courtesy luncheon will be served on Wednesday and Thursday.

Due to limitation of audience capacity, registration will be limited to 125. Acceptances will be made in the order of application. The registration fee is $30, but residents and interns will be admitted by a prior arrangement without charge when space is available.

The course will be held on the fourth floor of the North Clinic Building at Euclid Avenue and East 93rd Street in Cleveland. A copy of the program may be obtained by writing Dr. Charles L. Leedham, Director of Education, 2020 E. 93rd Street, Cleveland 6, Ohio.

## Relocations

Dr. Anna C. Jones, member of the medical staff at Lakin State Hospital, has accepted appointment as a member of the medical staff of the New Jersey State Hospital at Ancora in that state. She assumed her new duties there early in September.

* * * *

Dr. A. L. Starkey, former superintendent of Hopemont Sanitarium, is now affiliated with the San Fernando Veterans Hospital in San Fernando, California.

* * * *

Dr. George R. Mayfield, Jr., former pathologist at Memorial Hospital in Charleston, has moved to Columbia, Tennessee, where he is serving as pathologist and director of clinical laboratories at the Maury County Hospital in that city.

* * * *

Dr. G. J. Klein of Beckley has moved to Hazel Green, Wisconsin, where he will continue the practice of his specialty of surgery with offices at the Hazel Green Hospital and Clinic in that city.

* * * *

Dr. Harry F. Schneider of Delbarton has moved to Cincinnati, where he will continue in general practice. He has offices at 7176 Beechmont Avenue, Cincinnati 30, Ohio.

## New Heart Association Catalogue

A new catalogue, "Publications and Visual Aids for Physicians," has been prepared by the American Heart Association, and is available upon request from local heart associations. The catalogue describes Association professional materials including publications, audio-visual aids and models.

Copies of the catalogue may be obtained without charge by writing to the West Virginia Heart Association, P. O. Box 5336, Capitol Station, Charleston, West Virginia.

## State Soc. of Medical Technologists To Meet in Wheeling, Apr. 21-22

The annual meeting of The West Virginia State Society of Medical Technologists will be held at the McLure Hotel in Wheeling, April 21-22, 1961.

A varied and interesting program is being arranged, including the discussion of laboratory problems by a symposium composed of a pathologist, a hospital administrator who works with a pathologist, a hospital administrator without a pathologist, a technician from a hospital with a pathologist, and a technician from a hospital without a pathologist.

There will be a lecture on laboratory problems in Ghana and slides from that area will be shown.

Laboratory personnel who expect to attend the meeting are urged to make room reservations at the McLure Hotel just as soon as possible. Further information concerning the meeting may be obtained by writing Mrs. Elizabeth Anne Coleman, M. T. (ASCP), Public Relations Chairman, Wheeling Hospital, Wheeling.

## Employment of the Physically Handicapped

Employment of physically handicapped individuals has long been a serious and difficult problem. Periods of labor shortages, such as the World War II period, have helped direct attention to the economic and social aspects involved and have been instrumental in encouraging research and education dealing with the subject.

Even the conservative estimates place our population at 200 million before 1970; however, only about one-third of this growth will represent persons from 20 to 65—the productive, working years. Thus, the economic benefits to be derived from remunerative employment of our physically impaired citizens are obvious. Once again, an oft-repeated statement comes to mind—it is ability, not disability, that counts. Gainful and productive employment for the physically handicapped person is an admirable goal, socially, morally, and economically.—E. T. Eggers, D. B. A., in Industrial Medicine and Surgery.

**Dr. John W. Hash of Charleston, president of the State Medical Association, was the guest speaker at a recent meeting of the Logan County Medical Society. Left to right, Dr. Luke Combs, secretary of the Society; Doctor Hash; Dr. Harold Van Hoose, a member of the Council from the fifth district; and Dr. Ray M. Kessel, president of the Society.**

# The West Virginia Medical Journal

December, 1960 Vol. 56, No. 12

## Current Concepts of Erythroblastosis*

*J. Philip Ambuel, M. D.*

Direct reacting bilirubin is converted in the body from indirect reacting bilirubin by a series of enzymatic steps[1, 2] (Figure 1). Two enzymes, uridine diphosphate glucose dehydrogenase and glucuronyl transferase, are deficient in the newborn.[2] Oddly enough, they are present at birth but seem to require some practice before they function at full capacity, or, they are prevented from acting by some particular substance that inhibits enzyme activity. The capacity to conjugate bilirubin adequately, i. e., so that bilirubin excretion no longer is a clinically significant problem, does not develop until the age of 3 to 5 days in the term infant and 5 to 7 days in the premature infant. During this time indirect bilirubin accumulates because it can not be excreted by the body. It is the high indirect bilirubin that causes kernicterus.

Other factors also affect the degree of bilirubinemia. It is now known[3] that red cells of newborn infants have a very unstable concentration of glutathione due to a low level of glucose. Because of this deficiency the red cells of the baby are easily hemolyzed by various drugs such as vitamin K and the sulfonamides. The practical significance of this can be summed up thus:

1. Don't use the sulfonamides in the newborn period.
2. Don't use any drug in the newborn infant unless you know its potential hazards.
3. Use vitamin K sparingly: 1-2 mg. per day seems to be a safe level. Many institutions no longer use vitamin K routinely.

Finally, bilirubin transport is important. Odel[4] has shown that indirect bilirubin is carried in the plasma, bound to albumin. Several other substances including salycilates, sulfonamides and caffeine sodium benzoate compete with bilirubin for the binding sites on albumin. If these substances are added to the plasma, they will become bound to albumin and in effect "kick off" some of the bilirubin molecules. The result is more free, unbound bilirubin and perhaps an increased incidence of kernicterus.

These facts have clinical significance, at least for the sulfonamides. Silverman and his col-

### *The Author*

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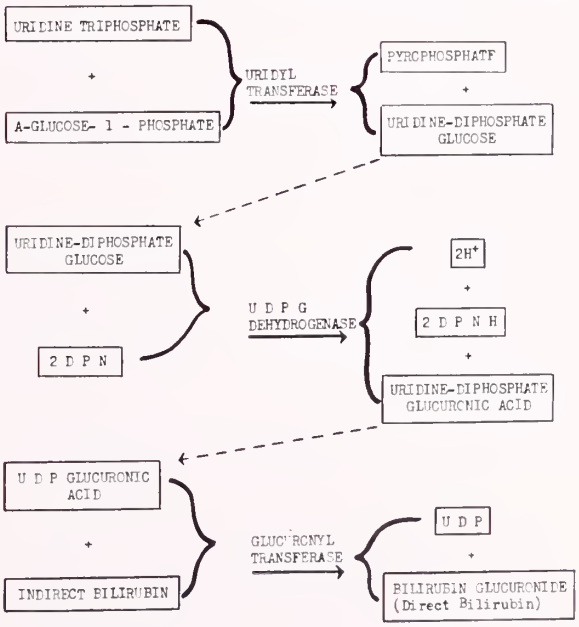


Figure 1

*Presented before the Annual Spring Clinical Session of the West Virginia Pediatric Society, at Huntington, March 31, 1960.

Submitted to the Publication Committee, June 7, 1960.

leagues,[5] in 1956, reported an "epidemic" of kernicterus among a group of prematures being treated prophylactically with gantrisin even though the serum bilirubin level in the infants was lower than that in the controls.[6] This difference in mortality rate and incidence of kernicterus is clearly due to the use of the sulfonamide.[6] Johnson, et al[7] have shown that the same mechanisms work in experimental animals, i. e., Gunn rats which have an enzymatic defect similar to that of the newborn infant.

In summary, the practical recommendations are:

Don't use sulfa drugs or salycilates in prematures and newborns.

As a general recommendation we can say that careful thought and evaluation should go into any therapeutic regimen instituted for the premature or the newborn. Of course, this is true for any patient, but because of the peculiar and often deficient physiologic system of the newborn, it is even more important for them. Even though there is, as yet, no proof of the clinical significance, experimental evidence[8] does show that albumin binds much less bilirubin at PH 7.0 than at PH 7.4. Because of this, one should prevent acidosis in a premature or newborn whenever possible. Optimal nutrition and fluid and electrolyte balance should be maintained.

One of the big problems in the care of a patient with erythroblastosis is the need for special laboratory procedures. The physician should make sure that his laboratory is able to give him reliable reports in these important determinations: blood typing, the Coombs test and bilirubin level. The bilirubin levels should be reported as indirect and direct rather than total bilirubin, since indirect bilirubin is the cause of kernicterus.

In discussing the clinical care of the patient, the spotlight will be focused on three topics:

1. Life-threatening situations.
2. Jaundice and kernicterus.
3. Pre-term delivery.

The first can be introduced with a paraphrase of a recent television drama, namely, "Goofs kill babies, sometimes." These goofs can be errors of omission as well as errors of commission. Heart failure is just as devastating to the baby when caused by hypervolemia which one has failed to relieve as it is when caused by excessive administration of intravenous fluid.

Figure 2 graphically demonstrates what the common life-threatening situations are. Most of them cluster about the exchange transfusion. Most of them have their effect directly on the heart. All of them have caused death.

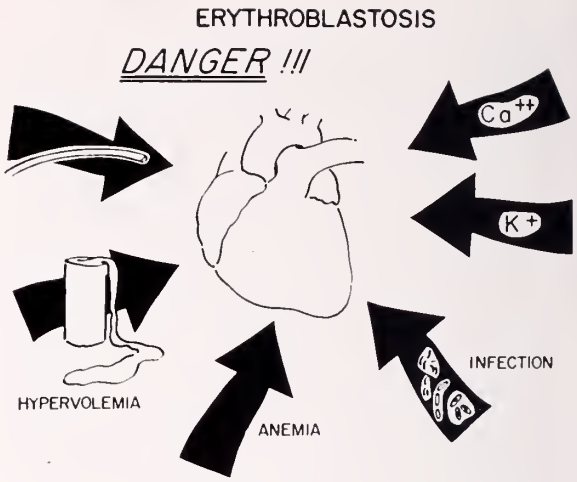


**Figure 2**

Table 1 lists the dangers and indicates what one should do to avoid them. Infection usually can be avoided by careful aseptic technique. We recommend that the catheter be removed at the end of the exchange transfusion. We do not routinely treat all exchanged babies with antibiotics and have found this to be satisfactory.

**Table 1**
**ERYTHROBLASTOSIS**

| *Danger* | *Prevention* |
|---|---|
| Infection | Strict asepsis<br>Remove catheter |
| Ca ++<br>too hi = heart block<br>too lo = tetany | 1-2 cc. at a time<br>slowly after each 100 cc. |
| K + | Avoid hemolysis |
| Catheter tip at S. A. node | Mark catheter |
| Hypervolemia | Maintain venous pressure below 10 cm. |
| Anemia | Careful follow-up |

Calcium may cause heart block if given too fast. It should be given very slowly, and not more than 1-2 cc. at any one time. During the time calcium is being administered, the heart tones and heart rate should be carefully checked.

Too much potassium can cause heart failure. Fresh blood would be ideal but bank blood no more than three days old is generally satisfactory. Avoid extravenous causes of hemolysis, e. g., excessive heat, excessive mechanical trauma to red cells.

If the tip of the catheter is in the heart, irregularities and occasionally heart block may occur. The right auricle may be only 9-10 cm. from the skin margin so, to avoid this danger, the catheter should be marked 6-7 cm. from the end so that it will not accidentally be threaded further than this.

Hypervolemia usually is due to heart failure and occurs in the patient who is severely ill at birth (hemoglobin usually below 9-10 Gm.) Deaths from heart failure can be reduced to a minimum if the venous pressure is maintained below 10 cm. of water during the exchange transfusion. One should check venous pressure several times during the transfusion by measuring the height of the blood in the catheter. The measurement can be made with a sterile steel rule using the skin margin as the zero point.

Anemia at birth is recognized as a rule, and is a part of the hypervolemia-heart failure problem. In the mildly affected baby who needed no treatment during the newborn period, the dangerous kind of anemia occurs at age 4-8 weeks. This anemia may be profound, and has been recorded as the cause of death. This can be avoided by a careful follow-up of all babies with erythroblastosis and by the use of blood transfusions when indicated.

Exactly when to do an exchange transfusion for hyperbilirubinemia is a perennially unsolved problem. One is caught on "the horns" of a dilemma. An exchange transfusion carries some risk even when done by an experienced operator, and it should not be done unnecessarily. The other "horn" is the fact that an early red cell exchange, which takes out bilirubin before it has been released from the red cells, and while it still is in the vascular compartment, is more effective than a bilirubin exchange which tries to remove bilirubin after it has been formed and has had a chance to penetrate the entire extracellular space and probably the intracellular space as well. The best one can do is to make an educated guess as to the ideal course of action. Our general "rule of thumb" is:

Exchange if:

1. Cord or 1-2 hour indirect bilirubin level is 5 or more.
2. 6 hour level is 7 or more.
3. 12 hour level is 10 or more.

Wait to exchange if:

1. Rate of rise is less than 0.25 (¼) mg./hr.

The original recommendation by Diamond, Vaughn and Allen,[9, 10] i. e., that an exchange transfusion should be done when the indirect bilirubin reached or threatened to reach 20 mg. per cent, has been confirmed by our experience (Table 2).

**Table 2**

**ERYTHROBLASTOSIS FETALIS**
**1958-59**
**Indirect Bilirubin Peaked Above 20**

| | |
|---|---|
| Total | 64 |
| Deaths | 4 |
| Premature | 2 |
| Term | 2 |
| Living Kernicterus | 1 |
| Total Kernicterus | 4-6.2% |

**ERYTHROBLASTOSIS FETALIS**
**1958-59**
**Indirect Bilirubin Peaked Below 20**

| | |
|---|---|
| Total | 171 |
| Deaths | 13 |
| Premature | 7 |
| Term | 6 |
| Total Kernicterus | 0 |

The peak indirect bilirubin level in the four babies who had kernicterus was:

| Term Babies | | | Premature = (2 lbs., 8 oz.) |
|---|---|---|---|
| 24.8 | 35.2 | 24.4 | 22.4 |

It is worth noting that no kernicterus occurred in those babies with levels of indirect bilirubin below 20.0 mg. It did occur, however, in one premature infant with a level of 22.4, and in full-term babies with levels of 24.4 and 24.8. Most of the 64 babies whose levels peaked above 20.0 mg. reached their peak between 20.0 and 24.0 mg. of indirect bilirubin.

The data on the hour of peaking are interesting. Table 3 gives the information for those who peaked with levels of 20.0 mg. indirect bilirubin; but those who peaked below 20 mg. had a similar distribution. As may be seen, many full-term babies did not reach their peaks until after 72 hours.

**Table 3**

**ERYTHROBLASTOSIS FETALIS**
**1958-59**
**Indirect Bilirubin Peaked Above 20**

| | | | | |
|---|---|---|---|---|
| Total | | | | 64 |
| Peaked later than 72 hours | 24 | Premie | 7 | Term 17 |
| Peaked later than 96 hours | 15 | Premie | 5 | Term 10 |
| 11 Prematures | | Average hour of peak | | 80 |
| 53 Term | | Average hour of peak | | 64 |

The question of pre-term (or early) delivery still is debated. It would be answered if someone could devise a reliable means of predicting which baby was doomed to intra-uterine death prior to 38 or 39 weeks. Various authors have discussed this. Evans[11] reports on 26 patients whose last previous pregnancy had resulted in a 36.7 per cent survival rate. Pre-term delivery (at least 8 months' gestation) in these patients resulted in a 91 per cent survival rate.

Chown[12] states: "If a woman has had one stillborn or hydrops, the chances are 9 out of 10 that the next Rh+ fetus will die before the 40th week. Induction at 34-36 weeks will save better than one-half of the babies who would otherwise

die. If a woman has had two or more stillborn or hydropic infants, almost 100 per cent of future Rh+ infants will die before 40 weeks. Induction at 32 to 34 weeks will save more than one-half that would otherwise die."

Table 4 shows the poor results at The Children's Hospital, Columbus, Ohio, during the past two years. There are a significant number of deaths in the premature group which are related to the fact of prematurity itself. Because of this, caution in recommending pre-term delivery seems indicated. In general we feel that pre-term is indicated if:

1. Previous pregnancies have resulted in one or more hydropic infants, or stillbirths due to erythroblastosis.

2. Father is homozygous. (If father is heterozygous, the infant has a 50 per cent chance of being Rh– and each case must be evaluated individually.)

**Table 4**

**ERYTHROBLASTOSIS FETALIS**

**1958-59**

**Poor Results**

| | |
|---|---|
| *Premature* | |
| Heart failure | 3 |
| Respiratory failure | 2 |
| No definite cause | 2 |
| Chloromycetin toxicity | 1 |
| Anoxia at birth | 1 |
| Kernicterus | 1 |
| *Term* | |
| Heart failure | 5 |
| Kernicterus | 2 |
| Total Deaths | 17 |
| Living kernicterus | 1 |

At the present time if the history is less severe than this, pre-term delivery probably is not indicated. Decision in these cases must await the development of more delicate diagnostic tools.

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# Guideposts in the Changing Scene

The past decade has witnessed changes in the tuberculosis scene in the United States greater than any but the most optimistic could have predicted. Tuberculosis was the 7th cause of death in the nation as a whole, whereas now it is the 14th. Last year the number of people who died of tuberculosis in the United States was only about one-fourth what it was ten years ago.

Thousands of people are still getting tuberculosis every year, but last year there were 50,000 fewer new cases reported than ten years before, and in the country as a whole, there is good reason to feel, reported cases reflect more truly the number of cases actually occurring than they did in the late '40's.—Edward T. Blomquist, M. D., in Journal, Arkansas Medical Society.

# Cardiac Emergencies in the Newborn*

*Don M. Hosier, M. D.*

THE newborn period is considered to be within the first two to four weeks of life. Since major readjustments occur in the cardiovascular system of the newborn, the diagnosis of a specific heart malformation is difficult. The signs and symptoms which may indicate that the newborn is in distress from a cardiovascular cause are as follows:

*Cyanosis.*—Cyanosis which persists for several hours after birth may be an indication of a heart anomaly. Other causes such as central nervous system damage or pulmonary disease must, of course, be considered.

*Murmur.*—Heard at birth or shortly afterward, a murmur may or may not be due to a cardiac anomaly. Approximately 2 per cent of newborn infants have a heart murmur and the possibility of the murmur, at this age, indicating a heart anomaly is approximately one out of twelve.[1] Conversely, some infants may be born with a serious cardiac anomaly and have no murmur during the newborn period.

*Weight.*—While this may not be too helpful in the newborn, it is of some significance in that failure to gain weight may be the first indication of the presence of cardiac disease.

*Fatigue.*—Fatigue in the newborn infant may be difficult to evaluate. Dyspnea when nursing, however, or frequent stops to rest while nursing, suggests the possibility of a heart anomaly. Occasionally one sees an infant who perspires profusely with any exertion, and this is seen frequently in infants who are in early heart failure.

*Respiration.*—An infant whose respiratory rate is continually greater than 40 per minute should be observed carefully for the possibility of a cardiovascular defect.

*Paroxysmal Dyspnea.*—This constitutes a cardiovascular emergency and more will be said later concerning it. An infant who has a paroxysmal dyspneic attack becomes deeply cyanotic, usually has gasping respirations, and may lose consciousness during such an episode.

*Stridor.*—Stridor also may constitute a cardiovascular emergency. There are a number of abnormal conditions not cardiovascular in nature, however, which can cause stridor in the newborn infant.

*Pulse.*—A persistently rapid pulse may be a sign of heart disease. As a general rule any infant who has a pulse of 200 or more beats per minute for more than twelve hours should be digitalized.

*Heart Size.*—The actual size of an infant's heart is extremely difficult to determine due to the poor chances of getting a good inspiratory film, and to the thymus gland shadow which may appear to enlarge the heart at its base. It is felt that a C-T ratio of more than 70 per cent in a newborn infant suggests heart enlargement, but minor degrees of heart enlargement are difficult to evaluate.

*Electrocardiogram.*—The electrocardiogram can be a most helpful adjunct in the diagnosis of heart disease in the newborn infant. One should become familiar with the normal electrocardiogram of the newborn, which shows right axis deviation and, in the precordial leads, a pattern of right ventricular preponderance. The right precordial leads (V4R and V1) will have an rSR' pattern. Minor deviations from this may be significant in that a qR pattern in these leads indicates more right ventricular preponderance than normal. The T waves also can be significant after the second day of life. For example, upright T waves in the right precordial leads suggest an abnormal amount of right ventricular enlargement for an infant. Inverted T waves in the left precordial leads (V5-V6) usually suggest some myocardial or endocardial damage.

Let us now consider those conditions which may be classified as cardiovascular emergencies.

### Cardiovascular Emergencies

*Paroxysmal Dyspneic Attack.*—Such an episode occurring in the newborn is indicative of pulmonary stenosis. As stated previously, the attacks are seen in infants who have shown some degree


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*Presented before the Annual Spring Clinical Session of the West Virginia Pediatric Society, at Huntington, March 31, 1960. Submitted to the Publication Committee, June 7, 1960.

of cyanosis following birth and on exertion become extremely dyspneic and deeply cyanotic, and may lose consciousness.

Treatment consists of placing the infant in the knee-chest position, giving morphine sulfate 1.0 mg. per 10 lbs. of body weight and administering oxygen. Once these episodes occur, surgery usually is indicated. A shunt procedure, either a Blalock or a Potts anastomosis, is the operation of choice. In approximately 50 per cent of these cases, the infant can be saved by such surgery and a more definite surgical correction attempted when the child is older.

Mention of the specific cardiac anomalies most likely to cause a paroxysmal dyspneic attack in the newborn seems pertinent here. The lesion most likely to cause such an attack is tetralogy of Fallot. In this condition, the infant's heart rarely is enlarged. The pulmonary vascularity noted on x-ray is reduced. A murmur may or may not be present during the first few weeks of life. A systolic murmur, however, may be heard along the left sternal border. An electrocardiogram will show right ventricular hypertrophy but may not be markedly different from the normal electrocardiogram of the newborn, with the exceptions mentioned previously.

An infant with tricuspid atresia may present with manifestations the same as those of the infant with tetralogy of Fallot, with one notable exception. The electrocardiogram in the former case will show left axis deviation, also evidence of left ventricular preponderance. In the case of any cyanotic infant with this type of electrocardiogram, the diagnosis is tricuspid atresia until proven otherwise. It might be stated that in infants with a tetralogy of Fallot or a tricuspid atresia anomaly, heart failure usually is not seen.

*Stridor with Choking Spells.*—Persistent stridor, especially in the presence of dysphagia and choking spells, calls for evaluation of the infant's condition with regard to the possibility of a vascular ring. The most severely involved cases are those of infants with a double aortic arch. It is uncommon, for example, to see an infant have difficulty on the basis of an aberrant right subclavian artery which crosses to the right arm behind the esophagus although such an anomaly can cause difficulty on occasion. An esophagram should be made to rule out vascular ring. Because of the possibility of aspiration, a liquid radiopaque substance such as lipiodol or gastrografin should be used rather than barium. It is difficult at times to rule out peristalisis or to obtain an x-ray at the exact time the radiopaque substance is in the area of constriction. Recently we have employed a special tube consisting of a plastic catheter* open at both ends, which passes through a latex balloon. There is an opening at the upper end of the balloon through which radiopaque liquid can be passed. The tube is positioned in the esophagus and the balloon is then filled with the radiopaque oil. Varying degrees of pressure can be exerted on the balloon and the infant can be placed in various positions for x-rays to determine an abnormal deviation of the esophagus. The device has proved helpful in many instances in determining whether or not a vascular ring was present. The infant with a vascular ring and in some respiratory difficulty should be placed with the neck extended and the head back. Surgery often is an emergency procedure.

*Rapid Pulse.*—Arrhythmias in the newborn infant can be cardiovascular emergencies. The most frequent arrhythmia is paroxysmal auricular tachycardia. Auricular flutter and ventricular tachycardia are much less common. Tachycardia in itself does not constitute an acute emergency in that an infant usually can tolerate a rapid pulse for twelve or eighteen hours before signs of congestive heart failure are noted.[2] Often, however, the infant is seen after tachycardia has been present for some period of time and the findings of cardiac failure are evident.

The treatment for tachycardia in the newborn is digitalis. While the possibility of conversion of ventricular tachycardia to ventricular fibrillation must not be lost sight of, instances of ventricular tachycardia have been terminated with digitalis. The treatment we prefer is Lanatocide C (Cedilanid) intravenously, using 0.03 to 0.04 mg. per kilogram of body weight as a digitalizing dose. One-half to three-quarters of the digitalizing dose is given intravenously and then one-quarter of the digitalizing dose is given intravenously every four to six hours until the infant is clinically digitalized or there are signs of toxicity. The maintenance dose, using digitoxin in place of Cedilanid, is calculated as one-fifth of the digitalizing dose in small infants and is given intramuscularly eight hours after the last intravenous dose of Cedilanid. A maintenance dose is given every twelve hours until it is certain that the infant remains digitalized. The digitalis may then be given once daily, by mouth or intramuscularly. If slower digitalization is desired, digitoxin is used intramuscularly; one-half the digitalizing dose is given immediately, then one-quarter every eight or twelve hours until the desired result or toxicity develops. The digitalizing dose of digitoxin is the same as for Cedilanid. The maintenance dose can be given once daily.

*Made by the U. S. Catheter and Instrument Corporation.

Digoxin (lanoxin) also may be used. The digitalizing dose is 0.03 mg. to 0.04 mg. per pound of body weight, and the maintenance dose is 0.01 mg. per pound of body weight daily. The maintenance dose usually is divided into two equal doses given twelve hours apart.

Maintenance digitalis should be continued for several weeks after an episode of tachycardia since in infants tachycardia is prone to recur. Oral medication is used in maintenance therapy.

Vagal stimulation may be tried when the infant with tachycardia is first seen but, in general, it has not been successful. Further attempts may be more rewarding after digitalis has been given, and may be made during the period of digitalization.

*Cardiac Failure.*—This condition is, of course, a cardiac emergency and the use of digitalis has been discussed. Other anticongestive measures such as phlebotomy, mercurial diuretics and oxygen should be used as necessary.

What are the defects most likely to cause cardiac failure in the newborn?

Coarctation of the aorta is a common cause of heart failure in the infant, and should readily be diagnosed. Femoral artery pulsations should be sought in every newborn, with simultaneous palpation of the brachial artery. In most infants with coarctation of the aorta, a marked discrepancy between the pulsations in the brachial arteries and the weak or absent pulsations in the femoral arteries will be noted. A flush blood pressure is helpful in that a difference of 20 mm. Hg. or more between the upper and lower extremity pressures generally is noted. On occasion pulses may not be palpated in any extremity and this may be the case in infants who are in marked heart failure or in those with aortic stenosis or atresia. In most cases of heart failure due to coarctation of the aorta in infants, anticongestive measures will bring about compensation. The infant then can be maintained on digitalis, and surgery can be deferred until his weight has reached a level somewhere between twenty-five and thirty-five pounds. At this weight the cross-section of the aorta is of sufficient size to allow for an anastomosis large enough to be adequate throughout life.

If it is not possible to compensate the heart by medical management, surgery may be necessary during the newborn period. The risk, however, is great and the possibility of a second operation later in life has to be considered.

An infant in failure due to aortic stenosis or atresia usually will not respond to anticongestive measures, and little can be offered by surgical means.

Another cause of cardiac failure in the newborn infant is endocardial fibroelastosis. No signs or symptoms (except slight dyspnea or some fatigue) may be noted until a mild infection develops which may place additional stress on the heart, with ensuing cardiac failure. A murmur is not usually heard in infants who have endocardial fibroelastosis. The most helpful information will come from the electrocardiogram. These infants generally show a left ventricular preponderance pattern, with inverted T waves over the left precordial leads. The treatment of choice is digitalis, and one may note a dramatic change in the child's condition after digitalization. There are recent reports in the literature[3] of cases diagnosed as endocardial fibroelastosis in infants who have been treated for four or five years with digitalis and who apparently have recovered completely.

In any case diagnosed as endocardial fibroelastosis, the infant should be continued on digitalis until he shows a normal sized heart and a normal electrocardiogram. While the prognosis is not good in many of these cases, it is not as invariably poor as was once thought. There seems to be little else to offer these infants. The use of pericardial poudrage has not been shown to be of significant benefit.[4]

Myocarditis from any one of a number of illnesses can cause cardiac failure in the newborn. Viral myocarditis in the newborn has been reported.[5] Again, it should be emphasized, that digitalis is given to infants in failure due to myocarditis and maintenance therapy should continue for three to six weeks after the failure is controlled.

There are two congenital heart defects which allow a left to right shunt and may cause heart failure in the newborn infant. One is a ventricular septal defect; the other is a patent ductus arteriosus. In both conditions a systolic murmur usually is heard over the precordium to the left of the sternum. A diastolic murmur may or may not be present in infants with patent ductus arteriosus. The heart is enlarged and the pulmonary vascularity greatly increased. A barium swallow will show evidence, in most instances, of enlargement of the left auricle. It often is difficult to differentiate these lesions in the newborn, but of great help in many cases is the palpation of the pulses. In infants with a patent ductus arteriosus, the pulses usually are bounding; this has been noted even in premature infants. If blood pressure can be obtained, a widened pulse pressure usually is found. In an infant in cardiac distress

due to a patent ductus arteriosus, surgical division is indicated when the diagnosis is made. In infants who are in distress from a ventricular septal defect, the treatment of choice is medical management until the child is large enough to undergo surgical correction without undue risk.

There is one other fairly common cardiac defect which causes cardiac failure and cyanosis in the newborn infant. The malformation is a transposition of the great vessels. Infants born with a transposition of the great vessels usually are cyanotic from birth. A teleoroentgenogram may not show the heart to be enlarged at birth but it will have rather an "egg-shaped" appearance, and may have a narrow base. The pulmonary vascularity will be increased. A repeat x-ray taken the fourth or fifth day of life will show the heart to have increased in size although maintaining the "egg-shaped" appearance; the increased pulmonary vascularity will be even more evident. As a rule of thumb, it might be stated that any infant who is cyanotic and has increased pulmonary vascularity probably will have some form of transposition of the great vessels. There is little that can be done for this malformation at the present time, and most of these infants do not survive.

While there are many other heart malformations and diseases which can occur in the newborn, the more common ones have been mentioned. It is to be hoped that many of the cardiac defects and diseases which at present cannot be cured, will, in time, no longer be major causes of neonatal death.

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# Should We Tell?

There is always a division of opinion both among physicians and families of patients as to whether or not the sufferer of cancer should be told the truth. Currently it is rather popular with individuals in public life and the various entertainment fields to give widespread publicity to their disease and its developments. Cancer has become a household word and is no longer avoided entirely. It is good to have the stigma removed. However, telling or not telling still remains an individual problem for the doctor and the family. Some patients demand to know and others request the truth be withheld.

The proponents of telling the patient everything feel the overall picture is better this way. The patient knows the truth and can plan accordingly. He or she does not spend his time wondering why he feels this way and gets off the circuit of running from one doctor to another. They all cling to the belief that whatever procedure has been carried out and treatment executed has been successful and a cure has been achieved. Some go so far as to deny their illness and live in a very comfortable dream state of pretending they do not know their real trouble. All agree in telling the patient that hope must be extended in whatever way possible. It may be the belief that a cure has been effected, a new drug, hormone, or entirely new approach is coming and will be in time for them.

Those who do not tell the patient feel that telling destroys all hope, hastens the end, and generally makes the patient more apprehensive and nervous about himself and his problem. Some may argue that the despondency of knowing may even enhance the growth of the tumor cells.

In the final analysis, we must be guided by what the family and patient want and by our good judgment as to what better fits the individual patient—Westchester Medical Bulletin.

# Infant Feeding Foibles*

*William O. Robertson, M. D.*

*"Indeed, the last half-century has seen a phase of stool scrutiny in clinical and social paediatrics the magnitude of which should not permit of its passing without notice and without epitaph. Until very recently infants' stools had been studied with a devotion paralleled only by the passionate zeal with which the Babylonians studied the liver and divined the future therefrom. . . .*

*"It is altogether fitting and proper that we should recognize the end of the allotted span of three-score years and ten to the clinical cult of coprology; and that we should dispatch the remains of this cult to the limbo of forgotten things. The era of the stool-gazers and stool-diviners is past."*[1]

How British of the British to call a stool a stool. The "end products" of an infant's digestion no longer warrant the worship they once received. Perhaps it also is time to cast a skeptical eye at the reverence paid the ritualistically prepared concoctions that constitute the raw materials of his digestion? Judging solely from the volume of journal articles and journal advertisements on *the* proper feeding of infants, the infant's formula continues to retain its almost-deity status in the field of pediatrics. While no doubt retaining a certain import, does it really deserve such attention?

Lest my purpose be misconstrued, let me state that it is to point out that in 1960 a formula's essential ingredients are indeed simple to provide, if not virtually impossible to withhold, provided moderation is observed. Furthermore, undue focus on minor variations in protein, fat or carbohydrate concentrations serves only to distract necessary attention from essential nonnutritional ingredients of feeding which lead to a successfully fed infant.

In contemplating the discussion which follows, it is suggested that the reader neither accept nor reject the somewhat "biased" arguments presented solely on the basis of their appearing in print. Rather, to paraphrase a currently popular cigarette advertising slogan, decide for yourself, casting aside enthusiasm and clinical impression as ultimate proofs.


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### Recollections of the Past

Looking back on early childhood, many of us can recall that eating spinach on a schedule, being fed hot cereal by a properly doting grandmother or hearing a pathetic maternal documentary on the difficulties involved in preparing the correct formula for an infant sibling, led us early in life to believe that the feeding of infants and children was indeed a complex matter. Obviously, it demanded exact measures, intricate procedures and precise care. Others will recall the aura of pomposity and mysticism that all too frequently surrounded discussions of infant feeding in medical school. There, for example, after enthusiastic endorsement almost bordering on blind worship of breast feeding, breast milk and the "naturalness" of the feeding process, we were introduced to those prenatal and postnatal rituals said to be mandatory to success. Yet, in spite of the proclaimed miraculous qualities, a paucity of breast feeding took place. Reluctantly at first but with conviction later, we were introduced to numerous philosophies of "artificial" feeding. Neglecting all too often to distinguish whether a stated advantage of a given formula rested on its nutritional make-up or on the fact that it had been sterilized in processing (thus ridding it of bacterial contamination), advocates of contrasting regimens claimed comparable or superior results. What impression other than one of confusion could possibly result? Surprisingly little data were available to show that even a majority, much less all, of the mothers presented with a scientifically contrived formula, did, in fact, succeed in whipping up the appropriate recipe in the kitchen.

Although this may appear to be an unnecessarily harsh indictment of a well-intentioned

*Presented before the Annual Spring Clinical Session of the West Virginia Pediatric Society, at Huntington, March 31, 1960.

Submitted to the Publication Committee, June 28, 1960.

movement, again, this is not my purpose. Instead, I would urge you to speculate on the number of errors that could not help but evolve were each and every one of the 4.5 million babies born annually in this country exposed to the complexities of formula construction prevalent only a short generation ago. Consider, also, if you will, the time spent, and wasted, by physicians and mothers, time which, when allotted to more productive activity, would have let both of these parties discuss and iron out far more crucial issues of child rearing.

That infant feeding routines should have traversed so many blind alleys is readily understandable. At the turn of the century both bacteriology and biochemistry (nutrition), like pediatrics, still were infant sciences. Hoping to eliminate the high morbidity and mortality rates associated with artificial feeding, pediatrics bet that the responsible culprit was to have a nutritional explanation. As we know in 1960, such was not the case; bacterial contamination was responsible. But in process of this discovery, many schemes were devised that continue to be passed down from generation to generation almost by tradition. Fortunately, today, the majority have been discarded so that providing a normal infant with a safe and nutritionally adequate formula is indeed a frightfully simple task, propaganda to the contrary notwithstanding.

### Complicating Conventions

Yet two specters loom on the horizon ready to complicate the process if but given the opportunity. The first of these is "allergy," that nebulous ogre which rarely can be proven to exist. The second is an extrapolation of the shibboleth, "Every child is an individual" to "Every infant has individual nutritional needs." That in rare instances unique needs occasionally do exist is evident in galactosemia and phenylketonuria, but hardly among "normal" infants. Furthermore, even if such mottos were founded on fact, there is as yet no reasonable evidence that such individual "needs" can be clinically recognized. While future research possibly may demonstrate a clear-cut need for modification of the above views, perhaps in terms of "allergy" or the effect of diet in infancy on adult body composition and function, invoking such pleas in 1960 is speculation at best. Facts are too few, knowledge too meager and bias too great. So, ignoring both possibilities for most if not all infants, a single formula—not necessarily any one particular formula—which can be relied on to meet certain simple criteria can be offered from birth onward (even up to adulthood) with assurance of satisfactory results.

Recently Panos[2] has emphasized that there are available on the market some 500 brands of evaporated milk, at least 58 brands of milk foods and 27 brands of carbohydrate modifiers. Significantly, none has been established as being superior nor, for that matter, inferior to any other. As a matter of fact, human milk, so long held up by teleologists as the model to be emulated by all artificial feedings, recently received the following commentary in the *British Medical Journal*, prompted, as it were, by two exhaustive and controlled studies of infant nutrition:

> "Most clinicians will, however, accept the conclusion that these (Swedish and British investigations of the inherent nutritional values of breast milk) and similar reports cannot be taken to fortify the arguments either for or against breast-feeding . . .
>
> "Most of the other conjectural advantages of breast-feeding which used to be so confidently advanced in lectures to medical students and midwives have now been removed by scientific inquiry. Even in the advancement of psychological reasons for breast-feeding it is well for the evangelist to proceed with patience and understanding."[3]

### Breast Feeding in the United States

Also for the breast feeding evangelist to note are the results of a recent survey[4] on the subject. Across the United States there was a remarkable variation in incidence of breast feeding, from a low of 12 per cent in the New England States to a high of 44 per cent in the far West. Multiparas breast fed significantly less frequently than did primiparas and for the entire group the "half-life" for "successful" breast feeding was just under two months. More important, no currently advocated supportive measures have been shown to be instrumental in prolonging this half-life. Since neither a nutritional nor a psychological advantage can be assured and because so many mothers consider it undesirable to breast feed (regardless of status symbols to the contrary), the physician can find little if any justification for an unrelenting alliance either with the pros or the cons of the currently popular movement to return the female breast to its primary physiological function. "To nurse or not to nurse" should remain for the mother to decide, not the physician or the nurse.

### Nutritional Requirements

Assuming a mother decides in the negative, what constitutes an adequate substitute? (Note the unfavorable connotation of this phrase!) What actually are the essential ingredients of a formula? Such a question might better be rephrased, "What are the nutritional requirements of the infant?", with the awareness that such can be satisfied via many pathways.

1. Calories: To function and grow, a young infant needs to ingest daily approximately 110

calories kg. The word "approximately" is to be stressed, for if the normal infant's "appestat" (appetite-hunger-satiation mechanism) were to me mis-set so as to allow an excess intake of as little as one ounce of milk (20 calories) each day for the first year of his life, about a 3 per cent error, he would be in position to accumulate almost 4 pounds of fat over and above his normal weight gain. Thus it is he rather than the slide rule on whom reliance must be placed to determine adequate caloric intake.

2. Protein: Because of controversial points and pressure the National Research Council has recently declined to declare a daily requirement of protein for the infant less than six months of age. Since, however, human and cow's milk proteins appear to have almost identical biologic values, a reasonable extrapolation can be made from available data which point to 2.2 to 2.5 Gm./kg. daily intake of protein as adequate for growth. What constitutes the minimum commensurate with normal growth is unknown. Similarly, the upper limits of tolerance have yet to be defined but, as Barnett and Edelmann[5] recently have been able to conclude, ". . . the role of renal function in the definition of optimal protein level has been assigned disproportionate significance." Thus, since cow's milk contains three times as much protein as breast milk, it must be severely watered down to qualify as an inadequate source of protein.

3. Carbohydrate and Fat: Apparently, except for barely trace amounts of certain fatty acids, the normal infant tolerates a wide variety, both qualitatively and quantitatively, of these two items. Consequently, his requirements are best measured in terms of adequate calorie intake rather than some mythical proportions.

4. Water: In spite of authoritative obfuscations to the contrary, if the infant's formula is prepared at approximately 20 calories to the ounce, neither dehydration nor water intoxication will ensue. No advantage will accrue either from further dilution or concentration.

5. Vitamins: Vitamania continues to be a national scourge, but May[6] has succeeded in clarifying the requirements for the infant with his editorial comment: "A normal infant requires no more than 30 mg. vitamin C and 400 units vitamin D in supplementation of his mother's milk or his artificial formula. . . . Supplementary vitamins A and B complex are not recommended for ordinary feeding practice, . . ." And actually many milk preparations are already fortified with vitamin D during processing.

6. Minerals: Two, in particular, should be mentioned: calcium, largely to be dismissed, and iron to be remembered. Although popular sayings stress 1 Gm. of calcium as a minimal daily requirement, breast milk provides only 330 mg. per liter. Furthermore, as Hegsted[7] has emphasized, the syndrome of calcium deficiency in man has yet to be described. Thus, it can reasonably be ignored although its counterpart, an excess of phosphorus, may on occasion be detrimental, i. e., neonatal tetany.

Iron deficiency, on the other hand, is the single most common deficiency disease seen in the United States, affecting 30 per cent of all infants according to one recent study.[8] A normal infant requires in the range of 6-8 mg. of elemental iron daily in the latter half of his first year to escape the deficiency state. For those who would employ "solid foods" as a source, let them examine Table 1. It illustrates the amounts of iron available in various "solids." Just try to satisfy the infant's needs with 12 tablespoons of liver or a half-dozen egg yolks; it can't be stuffed in. Since injectable iron no longer is commercially available, the alternatives would seem to be direct dietary supplementation ($FeSO_4$, alone or in cereals) or indirect supplementation via milk fortification. Such has already been done in the case of vitamin D and currently is being advocated by Medovy[9] for vitamin C. Iron supplementation of milk can and has prevented iron deficiency.[10]

**Table 1**

**IRON CONTENT OF INFANT "SOLIDS"***

| | |
|---|---|
| Cereals (dry) | 0.92 mg/tablespoon |
| Vegetables | 0.05-0.28 mg/tablespoon |
| Fruits | 0.05-0.32 mg/tablespoon |
| Meats | |
| Pork | 0.23 mg/tablespoon |
| Liver | 0.58 mg/tablespoon |
| Egg Yolk | 1.0 mg/yolk |

*A. A. P. Committee on Nutrition Report, Pediatrics 21:685 (April) 1958.

Examined in the aforementioned terms, an adequate formula is simple to prepare. Other variables, price, convenience and so on, may quite rightfully constitute the decisive variables as to choice. But to be stressed is the fact that an unnecessarily complicated formula is not only unable to be medically justified but, more important, because the frequent occurrence of kitchen error may be harmful.

### Contrast in 'Solids'

Where do "solids" fit in? In arriving at an answer, it is helpful to recall that in 1897 a universally accepted text recommended no vegetables for baby until his third birthday. Today

the figure is four months. The contrast is startling but of no established consequence. For those who would chant that solids provide concentrated calories, let them examine Table 2. Here it is

**Table 2**

**CALORIC CONCENTRATIONS OF INFANT "SOLIDS"***

| | |
|---|---|
| Cereals (dry) | 8 cal/tablespoon |
| Strained meats | 15 cal/tablespoon |
| Vegetables | 3-10 cal/tablespoon |
| Fruits | 10 cal/tablespoon |
| Egg yolks | 30 cal/tablespoon |

*A. A. P. Committee on Nutrition Report, Pediatrics 21:685 (April) 1958.

evident that except for eggs solid foods provide no more concentrated a source of calories than does milk. Since one should hesitate to rely on solids as adequate sources of iron and because otherwise they provide no advantage over milk (again in spite of old wives' tales to the contrary), any decision as to a precise time of introduction or a specified quantity of intake is arbitrary at best.

Thus, it is argued that to satisfy the infant's nutritional requirements presents little or no problem. Yet infant feeding continues as a problem. The reason is self-evident. In the vast majority of instances the problem exists not in the diet nor even in the infant but in the mother, and understandably so at that, as the following is intended to demonstrate. In another recent mail survey, the author presented a listing of 22 items to some 4,500 mothers of young infants, asking each to check specific items which caused her worry about her baby. Almost 60 per cent returned the questionnaire. Nearly half (42 per cent) indicated worry about the baby's digestion (spitting, burping, colic, gas, et cetera.) Three of the six leading sources related to his gastrointestinal tract. Little wonder the infant's formula is a focus of concern. It was noted, however, that 38 per cent of the mothers indicated the baby's breathing as a source of worry. Since air cannot be changed while the formula can, the latter all too often is, but with little justification. With experience, that is, an increase in parity, worry about both items plummeted. Is it not reasonable then to suggest that the young and anxious mother, reared in an atmosphere of the "hard sell" and superstition and given the responsibility of an infant who communicates in a completely nonunderstandable fashion, may misinterpret the normal for the abnormal? Searching for the scapegoat, she and her physician (who may be similarly affected) attack the only modifiable variable. The crisis passes and the change in formula is credited with still another miracle. (To the physician's consternation, a reversal of formulas, but in the opposite direction, previously had been effective in other infants).

### Conclusion

Is it not time to take stock of infant feeding problems, looking at them in terms of the infant and his mother rather than in terms of his diet? Cannot his formula be made as simple as possible, thus eliminating kitchen errors and their consequences? Careful attention to the basic issues involved, separating fact from fancy, would insure success. Such an approach deserves consideration, for just as science has cast aside divination by stool gazing, so too is it looking skeptically at formula juggling. Hopefully, this so-called art is approaching the twilight years of its existence.

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*. . . when we are planning for posterity, we ought to remember that virtue is not hereditary.*

THOMAS PAINE.

# A Medical Center for the 60's*

*Kenneth E. Penrod, Ph. D.*

August, 1960, perhaps records the most important milestone in the history of West Virginia medicine. I refer, of course, to the functional beginning of the new Medical Center, the fruition of a dream of this Association, dating back a long time.

The latest attendants report that the baby is unusually healthy, possessed of an excellent physique, and already showing signs of precocious activity. His appetite already has caused some dismay among those accustomed to thinking along lesser lines and this is but another clear indication that here we are dealing with not just an ordinary birth, but with a vigorous young giant.

And who fathered this progeny? You know as well as I that it was the West Virginia State Medical Association. And by this act you, the Association members, took upon yourselves a grave responsibility for the care, nourishment and proper upbringing of that which you have caused to be created. In no small measure will the ultimate contribution of this newly born babe be shaped by you.

As stated at the outset, we have just witnessed a milestone. It would be nice if we could all now mutually congratulate each other, say "well done," and have done with it. But such can not be. To have produced a fine, healthy sound-of-mind-and-body baby merits a pause for congratulations, but only a pause. A moment's reflection on the consequent responsibilities tends to cut short the celebration.

Let us plan together for the development of this new creation. In a way we must think of a long-range future, but the realities of life remind us that to plan very definitively for longer than an approximate ten-year period is impractical. Anyway, the first ten years of a child's life are said by the psychologists to determine in a large measure what he will become. So, predominately, what we are concerned about is the Medical Center of the 60's.

### Clinical Teaching Material

I am sure that one point on which all physicians will agree is the need for patients for the students to learn to practice medicine. There does exist, however, some divergence of opinion regarding the number, variety and kinds. In fact, professional medical educators are not in full agreement on this.

In a general sense, medical patients can be classified into three categories. There are, first, the chronically ill—the group requiring an enormous amount of attention and care, but a group with limited usefulness for the teaching of those aspects of medicine needed for everyday practice. Then there are those with acute diseases which are fairly easily identified, require comparatively simple treatment, and are not too time-consuming. Third the group of patients not critically ill, yet with an illness quite difficult to diagnose. Included are the prolonged headaches and certain of the metabolic diseases. Here, a clear history and good doctor-patient communication are of utmost importance. In many respects, it is this third group of patients which make the best teaching material. But characteristically, they are the most difficult for a medical school to obtain. They just are not often referred there for they are not considered sick enough. Too, practitioners often get the impression that these patients are not good teaching cases and therefore are not particularly wanted by the schools, so they do not send them. Then, too, they generally take care of all the acute work at home so the result is that the medical school often is left with an overwhelming predominance of teaching material of the poorest classification—those patients with old, long-established conditions. Such limitations impose a serious handicap on the student who subsequently must learn that the world of medical practice is vastly different from the one he knew as a student.

So it becomes obvious that you must share a cross section of your medical practice with the


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*Presented before the second general scientific session of the 93rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26, 1960.

Submitted to the Publication Committee, August 26, 1960.

new medical school if the school is to grow and prosper as you would wish. If this sharing is participated in by a large segment of the Association's membership no one individual need feel its impact. There is ample evidence to support the contention that the presence of a medical school increases rather than decreases the amount of clinical material in the immediate area. So, for those of you who have been looking forward to the establishment of the medical school in the hope of reducing your work week which, according to recent Public Health Service statistics, now averages 62 hours for physicians of this area in private practice, I cannot hold out much promise.

#### Augmenting Supply of Medical Students

A different area in which we of the medical school need a great deal of help may occasion a bit of surprise for some of you. It has to do with helping augment the supply of talented young men and women for the study of medicine. Nationally as well as locally, this is a problem of major concern as is pointed out in more detail in another article elsewhere in this issue of *The West Virginia Medical Journal.* But briefly, whereas over 2,000 additional beginning places in medical schools have been created since World War II, the total number and the per cent of college graduates seeking admission to a medical school have fallen alarmingly. Moreover, West Virginia ranks 37th among the states in terms of per cent of citizens who in the past few years have indicated a desire to study medicine.

Every practitioner of medicine in West Virginia has a grave obligation to attract some of our bright youngsters to the profession. This can be done in many ways, of course, including precept and example. But by some means the profession must actively compete with other fields for the best of young talent and no longer passively assume that they will "naturally gravitate to medicine." The alternative is passing of medical practice into the hands of the second raters. And it is the practicing physician who is in the best position to do something about the problem, by virtue of his standing in the community and since, traditionally, he is the one both student and parents look to for advice concerning a medical career.

#### Magnitude of the Financial Obligation

And, now, try as I might, I have not found it possible to leave the subject of money out of this talk nor, doubtless, did you expect me to. For I am certain that of all people, the physicians of this state have the clearest concept of the magnitude of the financial obligation imposed by the medical school and teaching hospital. They are aware of high hospital operating costs and know that they are unavoidable.

First, lets look at the current status of income from the soft drink tax. In the 1959-60 fiscal year the Medical Center realized a net income of $3,701,366 from this source, an increase of approximately $180,000 over the year before, and contributing greatly toward meeting the final construction costs and the procurement of approximately $800,000 worth of fixed equipment and hospital furnishings. The income, however, to be expected from this source next year is not easily estimated. It will be recalled that the last session of the legislature removed certain items from the soft drink tax list, and no one seems to know just what impact this will have. The only tangible evidence to date is that for the month of July just past the income was down $51,413, or 12.5 per cent, as compared with July, 1959.

We have yet to procure approximately another $800,000 worth of hospital equipment and to meet a final architect's bill of $154,000. We then can begin to think in terms of operating costs only. These are increasing day by day as we expand our operations and particularly as we assume maintenance, utilities and insurance for that sizeable building.

Medical schools are characteristically expensive to operate. In a recent study conducted by the Association of American Medical Colleges, 74 four-year medical schools were divided into three groups according to amount of annual budget. Twenty-five had an annual budget in excess of $3.5 million; 30 had a budget in excess of $2 million; only 19 had a budget of less than $2 million. Incidentally the study revealed the not too surprising fact that there is a significent difference in calibre between the student bodies of the 3 groups, favoring, of course, the schools with the higher budgets.

#### Cost of Operating the Teaching Hospital

When it is recalled that the other schools of the Medical Center must share in the total soft drinks tax receipts, it becomes readily apparent that not much of this fund will be available to underwrite the costs of operation of the University Hospital. Indeed, the fund was never conceived as a welfare fund, it was established as an education fund to underwrite the costs of the schools, not the hospital.

A rule of thumb used in teaching hospitals such as ours is that the costs amount to approximately $10,000 per bed per year. On this basis we may expect a total operational cost of some 5 million dollars when we reach full operation of the 522 beds.

Obviously we must recover almost all of this from sources other than the soft drinks tax. And the major part of these means must be through patient receipts. It is on this point that you, the referring source upon whom we are solely dependent, hold the key to our future. Should you send us only medically indigent patients, or patients unwilling to meet their obligations, we shall be in trouble very quickly. If, on the other hand, we receive from you a fair number of full pay patients, we shall endeavor to raise funds to help meet the costs of care of the others. In short, we are prepared to share with you the social obligations of care of the poor, but we cannot relieve you of this burden.

### Individual Contributions to the School

As your medical school is about to take its place as an integral part of this Association, it seems the appropriate time to discuss the matter of individual contributions to the school.

To an increasing extent, the physicians of this country are establishing a pattern of annual giving to the medical schools. This is as it should be, for ample evidence can be mustered to show that their own education was made possible to a large degree by a similar system. While there is no universally accepted figure representing the actual cost of educating a physician (professional cost accountants cannot agree completely on this complex issue), there is fairly general agreement that the figure is in excess of $2,500 per student per year. The medical students at West Virginia University pay $366 per year in tuition and fees. In effect each and every one is personally receiving scholarship aid of at least $2,134 per year, which in four years amounts to $8,500. Is it too obvious if I note in passing that this represents $200 per year for 42½ years—sans interest?

In this connection, the late Dr. Alan Gregg made a poignant observation in his recent book, *For Future Doctors*: "When I was a senior in college, the Harvard Lampoon built a new building. I remember the awful evening when we editors received the architect's bill for his services. It read, 'The Harvard Lampoon debtor to Edmund M. Wheelwright, Architect, for professional services, $25,000.' And then, 'Rebate from Mr. Wheelwright as an old Lampoon editor, $23,000. Balance due, $2,000.' That evening we learned a lot rapidly. I often have wondered whether medical schools would not do well to present on the tuition bills a statement of the real cost of a year's medical education, together with the rebate the student receives from sources he may never have thought about."

### 'Living Endowments'

Many medical schools in the United States have a significant "living endowment." This is not limited to the private schools, although these enjoy a great advantage in this regard. For instance, the medical alumni of the University of Virginia gave their medical school $44,383 in 1958, while for the University of Michigan the figure was $34,498 and for the University of North Carolina, $22,368. These sums were contributed through the mechanics of the American Medical Education Foundation for all purposes—building, scholarships, endowments, unrestricted, and the like. In that year West Virginia University received $4,077.27.

We hope that in the near future we can begin to realize increasing support through this channel for our many programs, and that every physician will feel an obligation to include a medical school in his social responsibility, along with his church and his community. And, of course, if such is to be we can think of no medical school more worthy than our own.

The next decade, the 60's, will be critical in establishing the new Medical Center on a firm basis. With continued close cooperation and help by the medical profession, plus understanding guidance, the youthful West Virginia University Medical Center will grow into a vigorous, responsible and useful component of society. To be orphaned at this critical stage can lead only to disaster.

It has been an eventful year since we last were together. Much has happened in Morgantown, but we have barely begun. We doubtless can look forward to another year at least twice as eventful.

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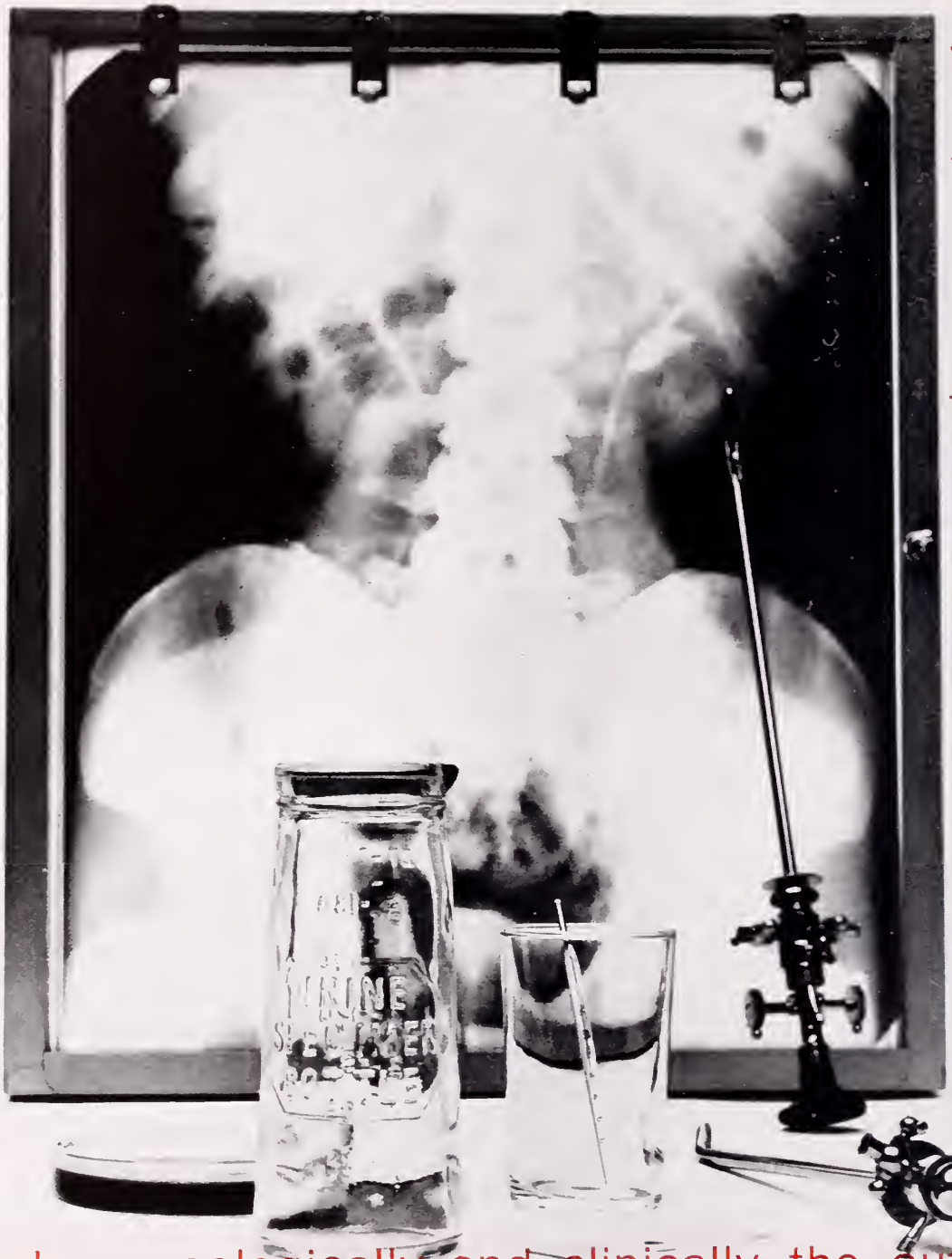
*. . . 'tis easy to see, hard to foresee.*

BENJAMIN FRANKLIN.



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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.

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# Our Future Doctors

## (The Medical School Admissions Picture Today)

*Clark K. Sleeth, M. D., and Kenneth E. Penrod, Ph. D.*

West Virginia stands at the threshold of a new era in medical education. For the first time, students will be able to receive the degree of Doctor of Medicine from an institution within the state. In addition, considerably larger numbers of applicants can be accepted for this course of study than previously was possible.

Much misunderstanding exists with regard to various aspects of admission to medical school. How many places are available in the United States today? How many candidates are seeking the available places? What factors are considered in selecting the applicants? How does the picture in West Virginia compare with the national picture, or with that in other states?

The young student (and his family) considering the possibility of medicine as a career, frequently and rightfully looks to the physician in the community for counsel and information on just such questions. It is thought that the data provided in this paper will be helpful in such circumstances.

### The National Picture

In September, 1960, new first-year classes were admitted to 83 four-year schools of medicine in the United States (including West Virginia and Kentucky, the newest additions). Three remaining two-year schools likewise admitted first-year classes.

**Table I**

**SUMMARY OF APPLICANT ACTIVITY DURING THE PAST THIRTEEN YEARS**

(Source: Association of American Medical Colleges)

| *1st Year Class* | *No. Persons Applying* | *% Male College Graduates Medical School Applicants* | *No. Persons Accepted* |
|---|---|---|---|
| 1947-48 | 18,829 | 10.7 | 6,512 |
| 1948-49 | 24,242 | 9.2 | 6,973 |
| 1949-50 | 24,434 | 7.4 | 7,150 |
| 1950-51 | 22,279 | 7.7 | 7,254 |
| 1951-52 | 19,920 | 8.7 | 7,663 |
| 1952-53 | 16,763 | 8.3 | 7,778 |
| 1953-54 | 14,678 | 7.9 | 7,756 |
| 1954-55 | 14,538 | 7.9 | 7,878 |
| 1955-56 | 14,937 | 7.5 | 7,969 |
| 1956-57 | 15,917 | 7.1 | 8,263 |
| 1957-58 | 15,791 | 6.5 | 8,302 |
| 1958-59 | 15,170 | 5.9 | 8,366 |
| 1959-60 | 14,951 | 5.5 | 8,510 |

Submitted to the Publication Committee, August 31, 1960.

*The Authors*

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During the past twelve years the number of persons annually accepted for enrollment in medical schools has increased by about 2,000. This has been made possible by the forming of new schools and by expansion of existing ones. During the same period the number of individuals seeking admission to medical schools has decreased markedly. Table I shows both trends clearly.

Thus we see that in 1949 there were 24,434 applicants for medical schools, of which number only 7,150, or 29.2 per cent, could be accepted. By 1959, the number of applicants had dropped to 14,951, of which 8,510, or 56.9 per cent, were accepted. While one might suppose that 14,951 applicants is an ample pool from which to select 8,510, it will be seen later that the picture is far more complicated than would at first appear.

During the period under consideration, college enrollments have been increasing. In 1948, baccalaureate degrees were granted to 176,146 men, in 1959, to 257,000. The number of applicants for medical schools in 1948 was equal to 10.7 per cent of the number of men receiving bachelor's degrees that year. By 1959, the figure was 5.5 per cent. The proportion of college men who apply for admission to medical schools has nearly halved in about a decade. It would be interesting to investigate the reasons for this shift in vocational objective. Since no real studies are available, one can but speculate that it may be related to the difficulty of admission to medical school a decade ago, or to the length or cost of a medical education. Perhaps the public image of the physician has changed adversely. Whatever reasons may be operative, our friends among the other professions which require prolonged educa-

tion and training also are noting a relative shortage of highly qualified applicants. Some observers note with optimism that college enrollment is expected to continue its recent rapid increase, but have we any assurance that this will reverse the recent trend of decreasing numbers and decreasing proportions of well qualified applicants for medical schools?

If the decrease in the number of applicants represented solely or even chiefly the disappearance of those poorly qualified or poorly prepared for the study of medicine, we might have small cause for concern. There is no evidence, however, that such is the case. One bit of quantitative measurement bearing on the situation is available, and concerns the difference in scores on the Medical College Admissions Test for accepted and nonaccepted applicants. (The Medical College Admissions Test is a test given nationally to all applicants to medical schools and provides a reasonable estimate of the intellectual capacity of the applicant in comparison with his fellow aspirants). During the past decade the mean score on the test for those accepted for medical schools has risen slightly, but the mean for those not accepted actually has fallen, an indication that there still are considerable numbers of poorly qualified applicants.

Let us return to the most recent figures for applicants and acceptances. Of 14,951 applicants for the 1959-60 class, 8,510, or approximately 57 per cent, were accepted. One must consider that among the unsuccessful were a number of repeaters who had not gained admission the previous year plus the ever present pool of those who apply year after year with little expectation of success. There are a certain number, too, who "take a flyer" after three years of college but who really plan a fourth college year if not accepted. Taking these into account, the admission rate for first-time applicants is well over 60 per cent.

### The Picture in West Virginia

Let us now look at how the State of West Virginia fits into the national picture just outlined.

It will be seen from Table II that West Virginia ranks 37th among the states in relation to the number of applicants to medical schools per 100,000 population. Ranked according to number accepted West Virginia is 44th of 49. (Data for Alaska and Hawaii are not available but the District of Columbia is included).

For the class entering in 1958 (the latest year for which complete data are available, 55 per cent of the number of applicants over the entire country were accepted. Among the various states the highest proportion of acceptees to applicants was 78 per cent, in South Dakota. Iowa, Vermont and Wisconsin each showed 71 per cent successful while at the other end of the scale Wyoming and Rhode Island showed 45 per cent and 37 per cent respectively. West Virginia with 47 per cent of applicants successful again ranked 44th of 49. It is of interest that of 25 states having admission rates above the national average, 20 were from among the 34 states having publicly owned medical schools.

The trend of West Virginia residents seeking admission to some medical school has followed the national picture fairly closely, as is true also of applicants to West Virginia University School of Medicine. It is to be borne in mind that not since 1935 has West Virginia University accepted a completed application for medical school from a non-resident of the state. In spite of some fluctuation in the total number of West Virginia residents applying to medical schools over the past decade, the number accepted at all schools has remained remarkably constant (Table III).

**Table II**

**MEDICAL SCHOOL APPLICANTS AND ACCEPTANCES PER STATE**

**1958-59 Entering Class***

(Selected Data)

| Rank—Applicants per 100,000 Population | State | Population (X 1,000) | Applicants per 100,000 Population | Acceptances per 100,000 Population |
|---|---|---|---|---|
| 1 | District of Columbia | 798 | 16.54 | 7.64 |
| 2 | Utah | 836 | 13.04 | 5.38 |
| 3 | New York | 16,098 | 12.88 | 6.99 |
| 37 | West Va. | 1,962 | 7.34 | 3.41 |
| 47 | Vermont | 368 | 4.62 | 3.26 |
| 48 | New Mexico | 789 | 4.31 | 2.41 |
| 49 | Maine | 923 | 2.93 | 1.73 |

*Source: *Journal of Medical Education*, 35 (2): 120, 1960.

**Table III**

**THE APPLICANT PICTURE AT WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE**

| | CLASS ENTERING | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1950 | 1951 | 1952 | 1953 | 1954 | 1955 | 1956 | 1957 | 1958 |
| West Virginia Residents Applying: | | | | | | | | | |
| To All Schools | 233 | 209 | 170 | 152 | 123 | 160 | 163 | 154 | 144 |
| To W. V. U. | 170 | 159 | 117 | 115 | 88 | 116 | 122 | 136 | 116 |
| West Virginia Residents Accepted: | | | | | | | | | |
| At All Schools | 62 | 69 | 69 | 72 | 65 | 71 | 79 | 70 | 67 |
| At W. V. U. | 31 | 31 | 31 | 31 | 31 | 31 | 31 | 40 | 42 |

One further point should be noted concerning medical school admission of West Virginia residents. Each year until 1957 more West Virginians started to medical school outside the state than in it and, in 1958, 25 of the 67 admitted

somewhere were accepted and enrolled in another state. Many of these received acceptance at West Virginia University also but elected to go elsewhere.

A class at any school can be selected only from among those who apply for admission, and it follows that the quality of the students at a given school tends to relate to the total number of applicants, or the pool from which the selections are made. In this country, it is customary to apply to more than one school, a form of "covering bets." The national average is about 3.9 applications per applicant. Thus the 14,951 individuals filed a total of 57,890 applications for admission to medical schools within the United States. As acceptance from a school of his choice is gained the student withdraws his applications to other schools. Therefore, at any given school, there is a difference between the total or gross number of applicants and the net or effective number from which the class must be chosen. Table IV shows this picture as it appeared at West Virginia University the past two years.

**Table IV**

**THE ADMISSIONS PICTURE AT WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE**

**1959-60 and 1960-61 Entering Classes**

| | 1959-60 | 1960-61 |
|---|---|---|
| Total Applicants (Gross) | 127 | 102 |
| Applications Withdrawn | 28 | 35 |
| Total Net Applicants | 99 | 67 |
| Total Admitted | 45 | 46 |
| Total Rejected | 54 | 21 |

It is of interest to compare the qualifications of the various applicants for admission to the West Virginia University School of Medicine with respect to whether they withdraw to go elsewhere, remain, or are refused admission.

A word of explanation regarding grade-point averages and Medical College Admission Test scores may be in order. Grade-point averages are calculated by assigning a value of 4 for each credit hour of work carrying a grade of "A", 3 for "B", 2 for "C", one for "D" and 0 for any other grade. The total number of grade points is divided by the number of hours of registration to secure an average. It often is said that a student must have an "A" average to secure admission to medical school. Table V illustrates the true state of affairs. One learns, too, that in quoting their records to family, friends and supporters, students sometimes omit from consideration a course they may have failed or may have repeated in an attempt to raise the grade.

The percentile figure used in quoting Medical College Admissions Test scores shows the relative position of the applicant with respect to all other applicants in the country for that year. Thus a percentile score of 60 means that only 39 per cent in the country were better, while a score of 20 means that 79 per cent of those taking the test showed better performance.

**Table V**

**ACADEMIC QUALIFICATIONS OF APPLICANTS TO WEST VIRGINIA UNIVERSITY**

| | 1959-60 | 1960-61 |
|---|---|---|
| Grade Point Average—Withdrawals | 3.02 | 3.05 |
| Grade Point Average—Enrollees | 2.96 | 2.99 |
| Grade Point Average—Rejectees | 2.43 | 2.20 |
| MCAT Percentile—Withdrawals | 60 | 56 |
| MCAT Percentile—Enrollees | 52 | 48 |
| MCAT Percentile—Rejectees | 30 | 20 |

(Each figure is the average of all individuals in that particular group.)

Medical school admissions committees at West Virginia University, as elsewhere, evaluate many factors other than grades and test scores in selecting from among their applicants. Letters from teachers, physicians and friends are valuable sources of information regarding background, motivation and sincerity of purpose. Personal interviews with applicants supplement these sources. It is, however, unfortunate but true that there is ample evidence, both here and at other schools, that applicants possessed of records poorer than certain minimums are extremely poor risks for completing the study required to become satisfactory physicians, no matter how much they may wish to be doctors of medicine. This fact needs to be brought home to many young men early in their pre-medical college years.

From Tables IV and V, it is all too apparent that we do not have nearly enough high quality applicants from West Virginia who wish to attend West Virginia University School of Medicine. That many of our best students go to other schools is evidenced by the superior qualifications of those who withdraw their applications to go elsewhere. It can be seen, too, that the rejected group is made up largely of applicants who are poorly qualified and poorly prepared as shown by the poor grades and their low position relative to other applicants over the country.

The facilities at the new Medical Center at West Virginia University have been built to accommodate 60 medical students per class. At present, if 15 or 20 more applicants were accepted they would have to come from a pool of applicants so inadequately prepared as to be virtually certain to fail in their attempts to cope with the increasingly complex and difficult work of the medical curriculum.

There is ample evidence that geographic restriction of applicants seriously affects the quality

of medical school classes. Table VI makes it clear that the present position of West Virginia University is untenable as regards the selecting of adequate numbers of highly qualified students.

**Table VI**

**TOTAL APPLICANTS TO THE 4-YEAR SCHOOLS OF MEDICINE IN THE UNITED STATES**

**Ranked in Decreasing Order, 1958-59 Entering Class**

| *Rank* | *School* | *Applicants* | *Acceptees* |
|---|---|---|---|
| 1 | New York Medical | 1,679 | 125 |
| 2 | Pennsylvania | 1,669 | 125 |
| 3 | Jefferson | 1,599 | 175 |
| 4 | Washington University (Saint Louis) | 1,414 | 86 |
| 5 | Northwestern | 1,383 | 132 |
| 78 | Iowa | 199 | 115 |
| 79 | Medical Evangelists | 191 | 96 |
| 80 | Arkansas | 179 | 91 |
| National Average—80 Schools | | 727 | 96 |
| West Virginia University | | 116 | 42 |
| Total West Virginia Residents Applying to All Schools | | 144 | |

The Association of American Medical Colleges recently has re-studied this question along with the effect of the amount of financial support accorded each school. It concluded that "Low expenditures plus geographic restrictions (less than 10 per cent nonresident students) seem virtually to guarantee that the average intellectual capacity of the student body will be poor to mediocre."

While we shall not for one moment categorize our students up to the present as suggested in the foregoing, we are nonetheless gravely concerned with the immediate future. A group of intelligent and inquiring students is a very real stimulus to excellent teaching by a strong faculty. Conversely, really good teachers confronted by a student body which offers no challenge soon will look elsewhere for a field in which their efforts will be more rewarding.

Clearly this is a problem which we must all face together. We urgently need to recruit more able students, and to urge them to demonstrate, throughout their college days, a sincerity and motivation which will result in good performance. This is not merely an imposed hurdle which must be gotten over to get into medical school, but a vital part of the preparation of the prospective medical student and physician, both as regards subject matter and attitude toward work. We need to convince the well qualified students intending to study medicine that West Virginia and its University Medical School offer unexcelled opportunities. We need to open the doors of our school to highly qualified students from other states to the extent that it can be done without displacing residents who have necessary minimal qualifications. Such an action not only would result in "capturing" a proportion of these good candidates for future practice in West Virginia, but would demonstrate the desirability of their own school to those residents of West Virginia who now choose to seek their medical education elsewhere.

Only by definitive action along the various lines suggested can we make certain that West Virginia will realize the great potential for medical education for which she has been preparing.

# Symptoms of Intoxication

Doctors in Germany have often stated that a serum alcohol level of over 1 part per 1000 is not compatible with safe driving, but the courts put the limit at 1.5 per thousand, allowing a margin for inexact determination, individual variation and so on. Recently improved laboratory methods have made it possible to reduce this margin for errors. The limit of 1 part per 1000 still allows the driver to consume four pints of beer, six to eight stronger drinks like gin, or many glasses of wine. In Norway, Sweden and Denmark, the highest value tolerated by law is 0.5 per thousand.

The symptoms of intoxication with blood levels under 1 part per 1000 are lack of inhibitions, diminished attention, tendency to take undue risks and an increased sensitivity to bright lights. A driver should abstain from alcoholic drinks for one and one-half hours before driving. If the accident risk is put at one in drivers who have had no drinks, it rises to seven in drivers with an alcohol level of 0.3 to 0.99 per 1000, to 31 with a level of 1.0 to 1.49 per 1000, and to 128 with levels over 1.5 per 1000.—Medizinische Monatsschrift, World-Wide Abstracts as quoted in Journal, Med. Assn., State of Alabama.

# Special Article

# The Arabic Medical Renaissance

*Joseph Krimsky, M. D.*

FROM the 8th to the 12th century when the Greco-Roman civilization apparently had perished with the downfall of the Roman Empire, when Europe was steeped in the blackout of barbarism and shabby backwardness, in those centuries of the Dark Ages, the Moslem lands offered a striking contrast of expanding culture and enlightenment. Bagdad, Cordova and other cities were vigorous, intellectual centers of learning. Libraries, hospitals, universities, public baths and gardens supplied the means and materials for refined and cultured living. The restoration of classic philosophy, literature and science to Western civilization was the notable achievement of Moslem and Jewish scholars, translators and commentators working diligently and fruitfully under the patronage of enlightened Arabic rulers.

In medicine, in optics, in astronomy and mathematics (algebra, for example), in chemistry (under the form of alchemy), Arabic thinkers and investigators not only preserved the knowledge and wisdom of the ancients but contributed richly of their own efforts in many fields of human advancement.

In our modern nomenclature, words such as alkali, alcohol, algebra, alchemy, azimuth, nadir, zenith, Aldebaran and numerous other terms of Arabic derivation, testify to the interests of Arabic scholars in mathematics, medicine, astronomy, chemistry and other fields of intellectual endeavor. Our numerals and our indispensable cipher came to us from the Arabs who developed their system of numbers on the basis of Hindu mathematics. What the Arabic scholars lacked in original inventiveness they made up in skillful adoption and adaptation to their diversified culture.

While the Arabic scientists made some distinguished contributions in many branches of medicine, they excelled in the special field of ophthalmology. Eye diseases are highly prevalent in the East. There are many endemic and epidemic inflammations, of which trachoma is the most frequently encountered. Cataract is extremely common. The Arabic doctors were exceedingly skillful in the practice of "couching," an ancient operation which displaced the opaque lens downward and away from the pupillary area where it caused obstruction of the vision. The method is a far cry from our modern cataract extraction but it served a useful purpose and was employed for many centuries.

Two outstanding works on eye diseases appeared in the 9th and 11th centuries. The authors were Hunain Ibn Ishak and Ali Ibn Isa. Both volumes later were translated into Latin and served as medical textbooks for a number of years. They were original and profound studies on the structure and function of the eye.

A book on physiological optics also was published in the 11th century by a Persian Arabic scholar named Alhazen. His chief advance over the ancient Greeks was his rejection of their theory that sight is an emanation of rays from the eye which strike the object visualized. Alhazen clearly demonstrated that, as in a camera, the visual image is formed on the inner surface of the eyeball. This and other optical discoveries by Alhazen profoundly influenced the progress of European optics.

The study of this eventful period in medical history leads us back to the 5th century A. D. The darkness of ignorance, superstition, mysticism and bigotry had settled over that vast territory which had known and been ruled by the law, order and culture of the Roman Empire. The Greek city of Byzantium had become Constantinople, the seat and center of the Greek church. It was a church-state theocracy, with the princes of the church very much in com-

***The Author***

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Submitted to the Publication Committee, May 24, 1960.

mand. Heresy was rampant, anathema and excommunication were lethal weapons.

Nestorius and his followers were expelled from the Greek church and driven out of the Byzantine Empire. It was through this apparently insignificant event involving a small Christian heretic sect that medicine, practically obsolescent in Europe, was transferred to Asia where, in Persia and Mesopotamia and later in Moslem Spain, it was revived and revitalized and for centuries burned with a brilliant light.

The Nestorians carried with them Syriac translations of ancient Greek works on philosophy, science and medicine. The learned ruler of Persia, Chosroes, welcomed them with open arms and provided munificently for the establishment of a Nestorian hospital in the Mesopotamian city of Edessa. The dormant Hellenic wisdom and knowledge, ignored and rejected in decadent Europe, found a haven and refuge among the pagan and Moslem Asians. Edessa became a famous and flourishing center of medical teaching and practice based on the writings of Hippocrates, Dioscorides and Galen and their schools.

Some years later the Nestorians founded another hospital and medical center in the Persian city of Jundi-Schapur. Thousands of patients and students flocked to these teaching and healing institutions, regarded by medical historians as worthy successors to Athens and Alexandria.

Ancient Greek medical knowledge and practice spread to Bagdad and as far west as Cordova in Moorish Spain. The disciples of Hippocrates and Galen now numbered among their greats the Persian Rhazes and Avicenna, the Arabic Averroes and Alhazen, the Jewish Ibn Shaprut and Maimonides.

The Nestorian Christians handed on the torch of medicine to the Persians who in turn transmitted it to the Arabs and Jews of the Moslem lands. The language of this medical renaissance was Arabic. The original Nestorian translations of the Greek classics into Syriac (an Aramaic dialect) were rendered into Arabic and Hebrew and later into Latin, by Arabic and Jewish scholars. The way was paved for the renaissance of culture and learning in Europe after the Dark Ages.

In the 9th and 10th centuries A. D. the Persians, Rhazes and Avicenna, wrote Arabic masterpieces in which they not only restored Greek science and medicine but added voluminously of their own experience, observation and practice. Avicenna's "Canon of Medicine," translated by a Jewish scholar into Latin, was an encyclopedic compendium of scholarship and practical knowledge. For many centuries it was the authoritative medical textbook in the Universities of Salerno, Padua, Bologna and Paris.

In the 11th century the Arabic surgeon, Abulcasim, wrote many works on surgery and devised numerous surgical instruments. The outstanding physician of the 12th century was Maimonides, a Spanish Jew who had fled to northern Africa from the fanatic Moslem Almohades who had invaded Spain from Morocco and had put an end to the friendly and tolerant Mohammedan treatment of Jews and other infidels.

The medical aphorisms of Maimonides, carrying on the tradition of Hippocrates, stress the importance of correct diagnosis, of diet, climate, mental and physical hygiene and the moderate use of simple medicaments. Maimonides, like his forerunners, Avicenna and Averroes, sought to integrate and correlate the teachings of Aristotle, Hippocrates and Galen with the wisdom of the Bible and the Koran. Fundamentally their medicine was derivative and a development of Hippocratic and Galenic thought and practice. The prayer of the 12th century philosopher-physician, Maimonides, deserves an honored place beside the Oath of Hippocrates:

> *"Preserve my strength, O Lord, that I may be able to restore the strength of the rich and the poor, the good and the bad, the friend and the foe. Let me see in the sufferer the man alone. When wiser men teach me let me be humble to learn; for the art of healing is so vast. Let me be intent on one thing, O Father of Mercy, to be always merciful to Thy suffering children."*

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*. . . let reason go before every enterprise and counsel before every action.*

ECCLESIASTICUS.

# Special Article

# Relative Value Index

*J. D. H. Wilson, M. D.*

During the past several years there has been much interest in Relative Value Studies in the medical societies of the western and midwestern states. Probably all have seen such a study, but few physicians in West Virginia have seriously considered the possible benefits of such a system.

A committee of the Harrison County Medical Society has been studying Relative Values for the past 16 months. In January, 1960, a sub-committee of the Committee on Medical Economics of the West Virginia State Medical Association was appointed to investigate the advantages, disadvantages, scope and problems to be encountered in determining a set of Relative Values for West Virginia physicians.

Having worked with fee schedules in various third party plans, the average physician in West Virginia distrusts and resists the imposition of fee schedules into medical practice regardless of purpose or adequacy of the schedule. However, in the everchanging patterns of social, political and economic life, we, like all members of our society, have been caught in a tide of change which must involve our scientific, economic and personal lives. While we must recognize and accept these changes which are becoming part of our environment, we, as physicians, must mold these changes for the maximum benefit of our patients, our State, and our medical profession.

Fee and benefit schedules under the title of "Medical-Surgical Coverage," but primarily "Surgical," came into being without a realistic relationship to actual fees for professional services. Without consideration of such factors as time, effort, competence and experience of one procedure to another, insurance companies and Blue Shield Plans had two basic criteria for developing schedules and benefit allowances, (1) a salable premium, and (2) meager statistics on relative frequency with which certain operations were performed.

Submitted to the Publication Committee, October 25, 1960.


## The Author

- **J. D. H. Wilson, M. D., Member, Medical Economics Committee, West Virginia State Medical Association, Box 1046, Clarksburg, W. Va.**


Blue Cross and Blue Shield were formed with the purpose of enabling the low income group to make prepayment of future hospitalization and physician expenses. The organizations were formed during depression years when the low income group was not able to pay even the expenses incurred by hospitals and physicians for their care. Therefore, the policies were written to cover operating costs. Now we have reached the point where the Blue Plans' ideas have formed the basis of other third party plans which feel that hospitals and physicians should bill these plans on a "cost" basis. The basic principle for formation of the Blue Plans has been lost and regardless of income, everyone can now purchase such coverage, but third party plans still want hospitals and physicians to adhere to the "cost" principle. When a majority of the patients have some type of prepayment insurance, it is economically impossible for hospitals and physicians to accept "operating cost" as full payment.

There are numerous fee schedules in West Virginia which affect each physician, such as State Compensation, Blue Cross - Blue Shield, Crippled Children, Rehabilitation, Cancer Control, D.P.A., Medicare, Veterans and numerous commercial plans. For the most part no consideration is given in the fee schedules as to the amount of time, effort, competence and experience required in handling one procedure as compared to another, since the physicians have not had a definite plan before discussing these schedules with the representatives of the various third party groups.

About four years ago the physicians of California presented a method of relating one medical procedure to another within the categories of medicine, surgery, radiology and pathology. This

system has been called the Relative Value Index. The Relative Value is a numerical unit which expresses the relationship of one professional service to another in certain categories. It is obtained by a statistical analysis of physicians' normal and customary charges as revealed in a survey of fees. The Index contains a code number, description of procedure, and a certain number of units (which are compared to each other in each category according to cost, time, effort, etc.) for each procedure. There are approximately 1900 procedures so listed.

The advantages of such a system are: (1) A coded nomenclature which covers most of the functions of physicians and which can be expanded when necessity demands; (2) Various procedures are compared one to another in each category; (3) While the Index is not a fee schedule as such, a fee schedule can be easily determined by multiplying the units by the proper coefficient; (4) Multiple fee schedules can be formulated by changing the coefficient and thereby foregoing the necessity of re-evaluation of each procedure for each new schedule; and (5) This is a program put forth by physicians for their use.

The disadvantages of a Relative Value Index are: (1) There is no possible method for compensating the better trained physician; (2) The cost of medical care will be raised if physicians do not use their NORMAL and AVERAGE fees in computing the Index; and (3) While the Index may apply statewide the coefficient may vary from section to section of the State due to different costs, per capita income, etc.

No one who has worked with this system feels that it is perfect, but it does put forth certain concepts which would enable us as physicians to negotiate and arrive at more intelligent and fair arrangements with the various third party groups with which we must deal as a group. Therefore, it is suggested that due consideration of this Index and System be given by the members of the West Virginia State Medical Association. Only by intelligent discussion and study will we arrive at a just and suitable answer, for our patients and for ourselves.

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# 'Whoso Would Be a Man'

MODERN society with its increasing complexities, is finding itself between the Scylla of social pressure and the Charybdis of conformity. In our attempts to cope with the confusing welter of stimuli assailing us, we find that we are afraid to question or challenge.

Our "experts" belabor us with literature on how to become socially integrated personalities, acceptable organization men or ovine community contributors. Society makes its demands on us and we gratefully follow its precepts, glad to be included in its faceless massiveness. The "Father-image" is all-good, all-knowing and who dares blow his trumpet at the Walls of Jericho?

Yes, who is there to stand up, lonely, afraid, yet daring to be individual and controversial? For years, many men of Medicine have avoided public exposure, sat silent in community debate lest an expression of opinion militate against them. Even so, the doctor is still a highly respected member of his community.

There are times calling for courage and frank discussion of problems. Medical advancement was possible because fearless men dared to be controversial. Society's best interests have always been served by recognizing the individual as a respected entity and not merely as an expendable cell in the societal macrocosm. Some doctors have shown us the way, have dared to be heard and now speak out forthrightly in our legislatures.

This far we cannot or need not all go, but surely we can know what we believe and be unafraid of the consequences of controversial expression. Stand up, speak out and be not fearful of disapproval. As Emerson said, "Whoso would be a man, must be a nonconformist."—Westchester Medical Bulletin.

# Special Article

# The Medical Examiner's System

*M. L. Hobbs, M. D.*


### *The Author*

- **M. L. Hobbs, M. D., Professor and Chairman of the Department of Pathology, West Virginia University, The Medical Center, Morgantown, W. Va.**


The Council of the West Virginia State Medical Association has gone on record unanimously as approving the recommendations of its Legislative Committee that a bill providing for the establishment of a Medical Examiner's System for the entire state of West Virginia be introduced at the regular session of the Legislature in 1961.

The proposed bill, originally drafted under the supervision of the West Virginia Association of Pathologists, a section of the State Medical Association, has been studied carefully by pathologists after consultation with chief medical examiners in other states where such systems have been successfully in operation for a number of years. The proposed bill then is the outgrowth of this study, conducted for some time, and represents the best proposals in the country.

Under the provisions of the bill, a commission on medical examinations would be created, with a chief medical examiner with power to regulate cremations and autopsies. Duties of coroners are set forth in detail. In essence, the bill provides more than that—a tested and tried system to investigate deaths in the state when required, plus any needed facilities to accomplish this end. This does not require that all deaths be investigated, for about 80 per cent of deaths are obviously from natural causes; however, experience has shown that the remaining 20 per cent need investigation. Of this 20 per cent, about one fifth actually prove to be medico-legal.

No attempt is made to attack the coroners or acting coroners, many of whom are trying to do the best job they know how, but rather to point out that the coroner's system is outmoded and especially ineffective in West Virginia. Many such coroners and/or acting coroners are justices of the peace who are trying to do a distasteful job but who admittedly have had little or no training or experience in such work. Furthermore, under this system these men are limited in authority, lacking or deficient in modern facilities, and oftentimes working without cooperation from anyone. As provided under the law, their investigations amount to a perfunctory duty which often yields little or no useful information.

Realizing that a coroner's system is outmoded, many states such as Maryland, Virginia and portions of New York, plus major cities, have adopted a Medical Examiner's System which has proved effective; therefore, this is not an experiment for West Virginia, but one patterned after successful operations in other states.

Control of such a system is best handled by a commission of representatives of interested people who by training or experience have an avowed interest in such deaths. One representative is to be from the Department of Public Safety (State Police); another from the West Virginia State Medical Association; and the third from the West Virginia State Bar. Certainly, such representatives would be in a position to have a personal interest in and some knowledge of the need for such investigations and the importance of a thorough study.

Such a commission as designated would have the authority to employ a competent Chief Medical Examiner, and to employ or authorize employment of other needed personnel to carry out the proper functions of this commission. Provisions are made to establish a well-equipped laboratory. All of these are necessary to carry out these functions. Those who follow the "who done its" know that a strand of hair may be the strand that hangs a criminal or a drop of blood may be the clue to a murder. Often a chip of paint under the spectroscope may identify a hit and run car. This is the modern, scientific approach—not a haphazard inquiry.


**Submitted to the Publication Committee, November 11, 1960.**

Many times we hear people say, "the person is dead, leave him be." In about 80 per cent of deaths society demands no more. But that remaining needs more than mere viewing of the body and the execution of a certificate of death. There are many valid reasons why the mode of death or reasons for death need study. Obviously, homicides or suspected homicides are high on the list of cases needing investigation for these are crimes. It is just as important to know that no crime has been committed to prevent indictment of an innocent person. As the density of population increases, there is usually an increase in the number of homicides. Also, this requires more careful scientific approach.

Secondly, suicides are more frequent with the increasing population. Too often these are officially recorded as suicide when a homicide has been committed or even a natural death has occurred. Such off-hand decisions may lead to mental anguish to the immediate family. Religious scruples are an important consideration as this makes changes in rituals and attitudes.

Thirdly, most individuals carry some form of insurance with double indemnity provisions and/or accidental benefits. Attorneys and courts know full well the necessity of adequate examinations and available facts surrounding such deaths, otherwise the beneficiary may not receive such just monies, or may make false claims. Fourthly, deaths attributed to industrial accidents or industrial hazards need careful study. While the Workman's Compensation Commission makes every known effort to make proper study, this body is handicapped by poor available facilities or circumstances which make such investigations impossible. These, of course, are germane to West Virginia.

Of the recorded 17,677 deaths in West Virginia in 1959, eighty homicides are a matter of record. As compared to Maryland which has a Medical Examiner's System, the per capita homicides are lower in West Virginia. Does this mean we have fewer crimes per capita? This infers that some of the deaths are homicides but not investigated. Criminals have escaped. We must face it, West Virginia is a good state in which to commit murder. A modern Medical Examiner's System in this state would make such instances much less frequent.

In West Virginia, as in other states, alcoholism and drug addictions are becoming more frequent. These, particularly alcohol, are the basis for many motor vehicle accidents. Provisions for alcohol levels have been made but too often chemical studies on dead bodies are not done. Such studies may often change the complexion of the case, even prevent conviction of an innocent person. We must always protect the innocent but only proper studies will erase doubts about guilt. Well-equipped, properly staffed laboratories, such as are provided for in this bill, would go a long way. Perhaps a single central laboratory for all this work may be best.

The operation and control of the proposed Medical Examiner's System is relatively simple and effective, with adequate coverage for every county and hamlet within the borders of this state. Under the direction and control of the commission, the Chief Medical Examiner is in charge of all operations and responsible to the commission. For each county and/or district in the state, there is to be a Deputy Medical Examiner, who is to be a physician properly instructed by the Chief Medical Examiner, and who may obtain expert advice or services at any time. The entire laboratory service would be available to every county. With such authority and facilities, no death need go without investigation when so indicated.

The Medical Examiners are not law enforcement officers but merely investigators who work closely with law enforcement officers, and with prosecuting attorneys in the various counties. Detailed records of such findings are to be kept, properly filed, and available to any authorized person or persons.

Law enforcement officers and others know the shortcomings of the present Coroner's System. Lawyers know too well that deaths are not properly investigated. Courts are faced with the dilemma of paucity of information on accidental deaths, murder indictments in which uncertainty exists as to reason for death, yet the courts are expected to render wise decisions. This cannot be done without dependable facts and evidence. Others are faced with situations in which expert service and/or advice as to death is needed. As of now this is done poorly if at all in West Virginia. This should not continue. Physicians should join hands with the West Virginia Funeral Directors Association, law enforcement officers, the West Virginia State Bar, the West Virginia Bar Association, the West Virginia Hospital Association, and other interested groups to establish a modern, up-to-date Medical Examiner's System—one that is workable, and within the price range that West Virginia can well afford. Of course, this will cost money. Actually, the cost to the counties should be approximately the same per case as under the present system. No single county can afford to do this. It must be on a

statewide basis. Sooner or later this will have to be done. Too long West Virginia has tolerated undetected homicides. Too many suspicious deaths are "viewed," not investigated.

Past experiences with legislatures and legislators have shown us that first a bill must be sold to a segment of people and then to the Legislature, for the Legislature does not buy without first being convinced that the people want it and are willing to pay for it. This may not be right, but that is what happens. It will happen in this case. Therefore, the physicians will have to spearhead this movement, seek the aid of other interested groups and present a united front to the people, to the Legislature, and to the appropriate legislative committees.

Without a question of doubt this is a good bill and should be enacted into law in this state. It does need explanation and selling to representative groups. This will require work, and it must be done.

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# Aged: Problems and Solution

The problem of aging begins at birth. As aging progresses, there is a mental, physical, emotional, and sociological growth. In this process man ages to the so-called middle age of life. Then, if he is not careful, he is catapulted into the senior citizen class.

This comes too quickly for those who have been too busy to prepare themselves for these tapering-off years. They are not ready to accept the fact that there is a new generation which thoughtlessly will put them much too soon on to the shelf of the aged. These are indeed very painful and sensitive years to be pushed into suddenly by forced retirement. There is nothing like boredom or inactivity to promote senility.

Because too large a segment of our aged population is not prepared for this period of life, we must develop a plan to fit each individual into the sum total of the community. We must find a plan to utilize all individuals to the maximum of their potentiality. We must make them feel needed and wanted, and not commit them to the Siberia of sitting and sighing. To accomplish these goals, several important facts must be taken into consideration. Members of the aged population have varying degrees of good or bad health, financial solvency, and desire to keep trying.

There are several things that are fairly constant with people in their senior years. Their wants are few—certainly contained within their ability to pay; very seldom do we see older people buy beyond their means, or go into credit financing. They have years of training and experience in their respective fields. Many are experts in their particular lines. Most of them have solved the problems of sociologic adjustment to their environments. Most of them are philosophic about the seeming catastrophies that face many of the younger generations.

All of them are very proud and confident of their ability to care for themselves and their loved ones, if given a fair chance. Forced retirement is not giving them a fair chance. The financially independent are in just as much need of being wanted and needed as are the completely indigent, but usually are more able to fill their ambitions for themselves in later years. They, too, can be committed to sitting and sighing, if they and we are not careful.—Russell L. Deter, M. D., in Texas State Journal of Medicine.

# Poison Control Centers

# In Operation 24 Hours a Day

## CENTERS IN OPERATION

**Beckley**
Beckley Hospital
1007 S. Oakwood Ave.
CL 2-6431

**Belle**
DuPont Belle Works
WI 9-4313
(Information Only)

**Charleston**
Memorial Hospital
3200 Noyes Ave., S. E.
DI 4-1741

**Clarksburg**
St. Mary's Hospital
464 Washington St.
MA 4-7611

**Huntington**
Cabell-Huntington Hospital
1340 16th Street
JA 5-0301

St. Mary's Hospital
2900 1st Avenue
JA 3-7466

**Parkersburg**
Camden-Clark Hospital
717 Ann Street
HU 5-5531

St. Joseph's Hospital
1801 Market Street
HU 5-5421

**Pine Grove**
The Pine Drug Store
TU 9-8500
(Information Only)

**Ronceverte**
Greenbrier Valley Hospital
MI 7-4411

**Weston**
Stonewall Jackson Mem. Hosp.
502 Main Avenue
Phone: 1775

# The President's Page

*Guest Author, Newman H. Dyer, M. D., Charleston,*
*State Director of Health*

## Financial Problems of the State Department of Health

I would like to express my deep appreciation to our President, Dr. John W. Hash, for the privilege of writing the President's Page in this issue of *The Journal.*

I also take this means of thanking the physicians of the state for their confidence and loyal support of the Health Department, without which we could not have functioned.

The greatest problem in meeting our ever-increasing needs for more and better health protection for the people of our state is a lack of funds. We have struggled for several years to make the public health dollars go as far as possible. Our state appropriation for public health has remained the same for the past three years, which is less than it was ten years ago.

The 1957 appropriation was 13.6 per cent less than in 1950. West Virginia was the only state with a decreased appropriation for this seven-year period. The average increase for the United States for the same period was 71.1 per cent.

Our employees have had but one salary increase in the last three years. It is most discouraging to these employees, who are skilled in the field of public health, when they fail to receive salary increases to meet the increase in cost of living.

In September 1959 the State Board of Health approved a budget increase for the current fiscal year amounting to $794,148. The major part of the increase was earmarked for financial assistance to the county health departments. The remainder was to be used for salary increases for employees working on the state level and for increased current expenses.

The Board of Public Works recommended to the Legislature an increase of $231,860, but the recommendation was not approved. It is our belief that if the state's economy had been in a healthier condition the recommendations would have been approved.

The State Board of Health has again approved the original requested increase amounting to $794,148 for next fiscal year. Our budget is now in the hands of the Department of Finance and Administration and the Board of Public Works. It is our sincere hope that it will be given favorable consideration by the 1961 Legislature.

The 1962 budget request is designed toward obtaining more funds to provide adequate basic public health services at the county level. These basic services include maternal and child health, public health nursing, communicable and chronic disease control, laboratory services, cancer and heart disease. Environmental protection requires additional trained public health personnel if our population is to be provided minimum public health protection.

If our Health Department is to continue up-to-date public health services in working with the physicians in the promotion of better community health, it is imperative that we have additional funds. We welcome your help.

# THE WEST VIRGINIA MEDICAL JOURNAL

*Official Organ of the West Virginia State Medical Association*

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.



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*Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.*

*Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.*


# EDITORIALS

## TUBERCULOSIS AND THE SEAL SALE

Despite the progress which has been made during the last half century against disease in general and tuberculosis in particular, the Great White Plague is still a major disease in West Virginia and throughout the nation as well. In 1919, the year in which the West Virginia Tuberculosis Association was founded, there were recorded 664 deaths from tuberculosis, and 516 in the following year. In 1940 there were 5,596 known cases of the disease, with 865 deaths. In 1959 our State had 6,427 cases reported, and in 1960 there were 541 new cases reported up to November 1. There were 71 deaths in the first seven months of this year.

West Virginia has somewhat greater morbidity and mortality rates than does the nation at large. For 1958 (the last year for which complete statistics are available) the entire United States had 37.3 new cases per 100,000 population and the corresponding figure for our State was 44.1, approximately 18 per cent above the entire country. The corresponding death rates were 7.4 and 8.3, showing West Virginia with a mortality rate of 12 per cent in excess of the national average.

As the years have gone by, the death rate from tuberculosis has decreased very materially but the morbidity rate has declined much less rapidly. This means that the treatment has improved all along but that prevention has lagged. We know that every new victim develops from a preexisting case. It would seem therefore that prevention could be attained, but the problem is not quite so easy of solution. A goodly number of existing cases do not know that they are infected, and a large number of known active cases either do not know what they should do, or wilfully decline to follow directions.

By far the greater part of the effort of the tuberculosis associations is educational and, as such, essentially prophylactic, and only by prevention can we ever eradicate tuberculosis. Treatment of existing cases is necessary, of course, but only by prevention can we develop a tuberculosis-free community in the sense that we now have typhoid-free and smallpox-free communities.

The Seal Sale is the only source of income of our T. B. Associations which are doing such important work. We bespeak therefore the active and enthusiastic support not only of medicine, but of all the healing arts and of the populace generally. Let's use the seal with the tuberculosis cross on each letter we mail between now and the time Santa Claus arrives.

## HYPOXIA AND CORONARY BLOOD FLOW

It has been known for a long time that hypoxia causes an increase in coronary blood flow. In 1925 Hilton and Eicholtz[1] demonstrated that during hypoxia there was an increased blood flow through the coronary vessels, so that an augmented blood flow through the heart muscle was supplied even though there were no changes in arterial pressure. These findings have been corroborated by a number of workers. For example, Green and Wegria[2] in 1940 found that if the lungs were ventilated with a gas mixture containing from 5 to 7 per cent oxygen, coronary flow was increased several hundredfold. In the main, studies have shown that the volume of coronary flow increases when oxygen is reduced to 8 or 9 per cent. Jochim[3] points out that hypoxia is a more powerful vasodilator of the coronary vessels than preparations such as sodium nitrite, amyl nitrite, histamine or xanthine derivatives.

The mechanism for enhancement of coronary flow, however, is not entirely understood. Green and Wegria concluded that hypoxia causes a relaxation of the walls of the coronary vessels. Wiggers[4] restudied the problem and concluded that augmented coronary flow during hypoxia was due in part to vasodilatation, but felt further that the intensified cardiac contractions materially aided coronary venous flow. Berne et al[5] reported that a moderate lowering of arterial oxygen content does not decrease coronary resistance by direct action on the vessel walls, but coronary vasodilatation in hypoxia appears to be related to myocardial hypoxia.

Haskel and Clowes[6] studied coronary flow and myocardial metabolism during hypoxia in adrenalectomized—sympathetectomized dogs. They concluded that the increase in coronary blood flow is not necessarily mediated by either the cardiac sympathetic nerves or the adrenal glands. They expressed the opinion that local metabolic factors are the primary determinants of coronary bloodflow.

It appears, then, that still more work is needed to explain the mechanism for the enhancement of coronary flow during hypoxia. Regardless of the mechanism involved, however, it is of great importance that hypoxia is capable of exerting such a powerful vasodilator action. It serves as an extremely valuable compensatory mechanism when the organism is subjected to severe hypoxia.

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## DON'T TAKE BLUE SHIELD FOR GRANTED

We live in tumultous times, when the pace of political history and social change seems to have taken on jet propulsion, along with our rockets and planes. And, though even our oldest Blue Shield Plans have been in operation for scarcely 21 years, they have become such an accustomed part of our medico-economic landscape that many of us, especially those who were not in practice when these Plans were created, already tend to take them for granted. Indeed, one hears too frequently our Blue Shield Plan referred to as "just another insurance company."

This casual remark misses a rather vital point, vital not only to the security of the Plan but to the future of medicine's free enterprise economy. For there are a number of important differences between Blue Shield and the insurance organizations in the field.

Perhaps the basic difference is that Blue Shield, unlike its commercial competitors, is not an end in itself, but only a means, a mechanism set up by doctors and patients to make it easier for patients to pay for medical care and to facilitate the physician's job of providing needed medical care to his patients. To an insurance company, the business is an end in itself. To us, Blue Shield is only an instrument designed to help physicians and patients meet their responsibilities to each other.

To an insurance company, a claim payment is a "loss"; to Blue Shield, a claim payment is a benefit, fulfilling the sole purpose of its existence. Blue Shield is run by physicians and public representatives for the benefit of the community. It's the one and only nationwide prepayment program the medical functions of which are guided and controlled by the medical profession, for the single purpose of helping physicians the better to serve their patients.

No, Blue Shield is not "just another insurance company." It is the main bulwark of private practice in America, our one strong shield against the threat of a state-controlled medical system.

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# GENERAL NEWS

## Three State Physicians Honored By Southern Medical

Three past presidents of the State Medical Association were awarded certificates of appreciation for services rendered to the Southern Medical Association during the annual meeting of that organization in St. Louis, Missouri, October 31-November 3.

Those honored were Drs. T. W. Moore, Walter E. Vest and Ray M. Bobbitt, all of Huntington. Drs. Moore and Vest are past presidents of the Southern Medical Association, and Doctor Bobbitt is a past councilor.

**Dr. Albert C. Esposito of Huntington, left, was reelected secretary of the Section on Ophthalmology and Otolaryngology of the Southern Medical Association during the annual meeting in St. Louis. Shown with him are Dr. Lyle M. Sellers of Dallas, Texas, center, a speaker on the program; and Dr. Miles L. Lewis, Jr., of New Orleans, Louisiana, chairman of the Section.**

The certificates were presented to the recipients during the President's Luncheon on November 1.

Dr. Howard A. Swart of Charleston, councilor from West Virginia, attended the meeting and was present at all sessions of the Council.

### Doctor Esposito Renamed to Post

Dr. Albert C. Esposito of Huntington was reelected secretary of the Section on Ophthalmology and Otolaryngology of the Association. He was in charge of arrangements for the Section program during the four-day meeting, and he will have the same responsibility at the 1961 meeting in Dallas, Texas. Dr. Miles L. Lewis, Jr., of New Orleans, is chairman of the Section.

### Mrs. Huffman Named Auxiliary Councilor

Mrs. J. C. Huffman of Buckhannon, a past president of the Woman's Auxiliary to the State Medical Association, was named to a two-year term as a member of the Council of the SMA Auxiliary. She succeeds Mrs. Ross P. Daniel of Beckley.

### Alabama Physician Named President

Dr. Lee F. Turlington of Birmingham, Alabama, was installed as president of the Association at the President's Dinner on November 2. He succeeds Dr. Edwin H. Lawson of New Orleans, Louisiana.

He had been named president elect a day earlier to succeed the late Dr. Tom D. Spies of Birmingham. Doctor Spies, who had been named president elect at the 1959 meeting in Atlanta and who would have been installed as president last month, died earlier in the year.

Other officers were elected as follows:

Dr. A. Clayton McCarty, Louisville, Kentucky, president elect; Dr. Fount Richardson, Fayetteville, Arkansas, first vice president; and Dr. Grayson Carroll of St. Louis, Missouri, second vice president.

Dr. R. L. Sanders of Memphis, Tennessee, a past president, will serve during the coming year as chairman of the Board of Trustees, and Dr. George D. Wilson of Asheville, North Carolina, as chairman of the Council. Dr. R. H. Kampmeier of Nashville, Tennessee, will continue as editor of the *Southern Medical Journal.*

### Distinguished Service Award

Dr. Everett Lain of Oklahoma City was selected as the recipient of the Distinguished Service Award of the Southern Medical Association. Dr. T. W. Moore received the award in 1958.

The second Seale Harris Award was presented to Dr. N. C. Hightower of Temple, Texas, for outstanding work in the field of internal medicine. The first recipient was the late Dr. Tom D. Spies.

The Research Medal for meritorious and original research work in contributing to medical science was awarded to Dr. Leslie V. Rush of Meridian, Mississippi.

### State Physicians Attend Meeting

A large number of West Virginia physicians were among the more than 2,000 doctors who attended the meeting. Overall registration, including members of the Auxiliary, guests and exhibitors, exceeded 3,500.

Headquarters for the meeting was the Sheraton-Jefferson Hotel. General scientific sessions and section meetings were held in Kiel Auditorium.

## Dr. Kathryn Rainbow Named Head Of Lakin State Hospital

Dr. Kathryn A. Rainbow of Lakin has been named by Governor Cecil H. Underwood as superintendent of Lakin State Hospital. She succeeds Dr. Mildred-Mitchell Bateman who last July accepted appointment as supervisor of the division of professional services of the State Department of Mental Health. Doctor Rainbow has been serving as acting superintendent of the Lakin Hospital since July 8.

Doctor Rainbow is a graduate of the Fort Valley Georgia State College and received her M. D. degree from Meharry Medical College, Nashville, Tennessee. She was awarded a fellowship by the National Foundation for Infantile Paralysis and served a two-year residency in pediatrics at Freedman's Hospital in Washington, D. C.

She has been a member of the staff of the Lakin Hospital since 1954 and is a member of the Mason County Medical Society, the West Virginia State Medical Association and the American Medical Association.

## Allergists to Meet in Dallas, Mar. 12-17

The American College of Allergists' Graduate Instructional Course and 17th Annual Congress will be held at the Statler-Hilton in Dallas, Texas, March 12-17, 1961. Full information concerning the meeting may be obtained by writing John D. Gillaspie, M. D., 2141 14th Street, Boulder, Colorado.

## Relocations

Dr. Andrew J. Pasquale, a member of the surgical staff of the Grant Memorial Hospital in Petersburg, has moved to Georgetown, Ohio, where he will continue the practice of his specialty of surgery.

## N. E. Florida Heart Assn. Sponsors Cardiovascular Seminar

The 8th Annual Cardiovascular Seminar, sponsored by the Northeast Florida Heart Association, will be held in the Prudential Auditorium at Jacksonville, January 26-28, 1961.

Participating physicians will include William Dock, M. D., professor of medicine, New York State University; Lewis Dexter, M. D., assistant professor, Harvard University Medical School; Milton Rosenbaum, M. D., professor and chairman, Department of Psychiatry, Albert Einstein College of Medicine; and Richard Ebert, professor and chairman, Department of Medicine, University of Arkansas School of Medicine.

Full information concerning the program may be obtained by writing Daniel R. Usdin, M. D., President, Northeast Florida Heart Association, 1628 San Marco Boulevard, Jacksonville 7, Florida.

## Medical Meetings, 1961

The following is a partial list of national, state and district medical meetings scheduled for 1961:

Jan. 9-11—Medical Licensing Board, Charleston.
Jan. 26-29—Cardiovascular Seminar, Jacksonville, Fla.
Mar. 6-8—New Orleans Grad. Med. Assembly, New Orleans.
Mar. 6-9—S. E. Surgical Congress, Miami Beach, Fla.
Mar. 12-17—American College of Allergists, Dallas, Texas.
Apr. 10-12—Am. Acad. Pediatrics, Washington, D. C.
Apr. 17-20—AAGP, Miami Beach, Florida.
Apr. 21-22—W. Va. St. Soc. Med. Technologists, Wheeling.
May 8-12—Am. Coll. Physicians, Miami Beach, Fla.
May 19-21—W. Va. Chap. AAGP, Civic Center, Charleston.
May 22-25—Am. Urological Assn., Los Angeles.
June 22-26—ACCP, Hotel Commodore, New York City.
June 26-30—Annual Meeting, AMA, New York City.
**Aug. 24-26—W. Va. St. Med. Assn., The Greenbrier, White Sulphur Springs.**
Oct. 2-6—Am. Coll. Surgeons, Chicago.
Nov.—Southern Medical Assn., Dallas, Texas.
Nov. 28-Dec. 1—AMA Clinical Meeting, Denver.

West Virginians attending the annual meeting of the Southern Medical Association in St. Louis are shown with the new president, Dr. Lee F. Turlington of Birmingham, Alabama, following the President's Luncheon on November 1. Left to right, Dr. and Mrs. Ray M. Bobbitt and Dr. Walter E. Vest, all of Huntington, and Doctor Turlington. During the luncheon meeting, Drs. Vest and Bobbitt received certificates of appreciation for services rendered to the Association.

## Cancer Committee Asks For Support Of Cancer Detection Program

At a meeting of the Cancer Committee of the State Medical Association, held in Charleston on November 5, unanimous approval was given to the continuation of the Cancer Detection Program of the American Cancer Society. The chairman, Dr. Theodore P. Mantz of Charleston, presided at the meeting. The program had previously been approved by the Council of the State Medical Association.

Notice of the action of the committee will be given the presidents and secretaries of all local units of the West Virginia Division of the ACS, officers of which will be advised that they may contact Dr. Chauncey B. Wright of Huntington, a member of the committee, for additional information concerning the program.

### All Hospitals Reporting to Central Cancer Registry

It was brought out at the meeting that all of the hospitals in West Virginia are reporting to the Central Cancer Registry.

Miss Ann Rouse, administrative assistant of the Division of Cancer Control, State Department of Health, who represented Dr. N. H. Dyer at the meeting, said that while the Division of Vital Statistics always knows how many cancer patients have died, it does not have information concerning the number who are still living. She said that this information is necessary if we are to know the magnitude of the problem in West Virginia.

Miss Rouse emphasized the fact that only cases of cancer diagnosed since 1957 are reported.

### Cancer Committee Recommended for Each Hospital

The Committee went on record as recommending that a cancer committee be set up within the staff of each hospital in the state for the purpose of aiding in reporting new cancer cases and providing a follow-up program.

A statistical report will be furnished all participating hospitals at the end of the first five-year period, which will reveal the experience of West Virginia for comparison with other states.

### The Cancer Detection Program

The Cancer Detection Program, initiated in November, 1959, is well under way, but Dr. Hu C. Myers of Philippi, president of the West Virginia Division of the ACS, told the committee that local medical societies have not given the support that is needed to make the program a complete success. He emphasized the fact that no attempt would be made to put the program into effect in any part of the state without the approval of the local medical societies.

The committee discussed the question of ethics in connection with the listing of the names of participating physicians in a folder or booklet on the subject of cancer detection. It was brought out that the folder, "Your Cancer Detection Program," must list the names of participating physicians if the lay public is to know what physicians will give the cancer detection test.

The committee was told by Doctor Myers that physicians over the state have been most cooperative in the society's efforts to make the cytology program a success.

Besides Drs. Mantz and Myers and Miss Rouse, the meeting was attended by Drs. J. I. Markell of Princeton, William D. McClung of Charleston, D. Franklin Milam of Morgantown, Russell A. Salton, Jr. of Williamson, C. Truman Thompson of Morgantown, and C. B. Wright of Huntington, all members of the committee. Others present at the meeting were Dr. John W. Hash of Charleston, president of the State Medical Association, and J. Ross Hunter, Jr. of Charleston, secretary of the West Virginia Division of the ACS, and Charles Lively, secretary ex officio.


*To all of the Members*
*Of The West Virginia State*
*Medical Association*

May the love of your family,
The joy of your friends,
The thrill of your toil, and
The enchantment of

CHRISTMAS

Combine to make this your

HAPPIEST YULETIDE
and
BEST NEW YEAR!

John and Beulah Hash

Chorleston, W. Vo. December 1, 1960


## Mrs. Claude R. Davisson Appointed To State Board of Education

Mrs. Claude R. Davisson of Weston has been named by Governor Cecil H. Underwood as a member of the West Virginia Board of Education for the term ending November 4, 1963. She succeeds Dr. J. H. Murry of Gary, resigned.

Mrs. Davisson, wife of Dr. Claude R. Davisson, has for several years been an active member of the Woman's Auxiliary to the West Virginia State Medical Association. In addition, she has participated actively in local and state civic and club affairs. Currently, she is serving as parliamentarian of the State Auxiliary.

## Thomas Memorial Hospital Establishes Volunteer Chaplaincy Program

A "Volunteer Chaplaincy Program" has been established at Herbert J. Thomas Memorial Hospital in South Charleston through the combined efforts of area ministers, members of the medical staff and administrative personnel at the hospital.

Basically, the program consists of (1) a weekly vesper service in the hospital, and (2) the voluntary services of a qualified minister who serves in the capacity of hospital chaplain for a one-week period.

Initial plans for the program were formulated following the death of Dr. Reuben F. Wohlford in the spring of 1959. His colleagues on the medical staff decided to make long-range plans for the construction of a non-denominational chapel as a memorial to Doctor Wohlford.

### Dr. Tracy Spencer Heads Chapel Committee

Dr. Tracy N. Spencer, Jr., of South Charleston, was named chairman of the chapel committee and he immediately sought the active cooperation of the hospital's board of trustees and the ministerial associations of South Charleston, St. Albans, Nitro and Dunbar.

The Rev. Chester McCullough of Nitro conducts weekly vesper service at Herbert J. Thomas Memorial Hospital in South Charleston. The hospital library is converted into a chapel each Sunday for vesper services pending completion of plans for the construction of a new chapel.

Several meetings between representatives of these groups were held early in 1960 with the result that the board approved the idea of including a chapel in the overall expansion plans for the hospital. In the meantime, it was decided to convert the hospital library into a chapel each Sunday for vesper services to be conducted by participating ministers.

Preliminary plans pertaining to the services of ministers as volunteer chaplains in the hospital also were discussed at that time. It was decided, however, to concentrate on the inauguration of vesper services before moving ahead to the second phase of the program.

### Library Converted into Chapel

Conversion of the library into a chapel was under the supervision of George I. Mattix, hospital administrator, and he received full cooperation from the United Church Women of South Charleston and the physician's chapel committee.

The first vesper service was held late in May and services have continued weekly without a break. Average attendance at the half-hour service has been 37. The service consists of hymn-singing, prayer, meditation and a brief sermon.

Patients are reminded of the service by a card placed on breakfast trays each Sunday morning. Before a patient is permitted to attend the service, he must obtain permission from the attending physician.

The Rev. John S. Lyles of Dunbar, minister of the First Presbyterian Church in that city, who is currently serving as chairman of the hospital chaplaincy committee, said that the purpose of the service is to "help patients make positive use of their faith in meeting and handling what is happening to them in their hospital experience, and to provide continuity in their regular religious participation."

Mr. Lyles said the vesper services have proved mutually beneficial to patients and their families, hospital personnel, the medical staff and to the ministers.

"Of most importance," he said, "is the fact that full cooperation was obtained from all involved groups. A sort of uncertainty or wariness (doctors toward ministers, ministers toward hospital, etc.) at the beginning quickly changed to working cooperation when we sat down to discuss our common objectives—the best way to provide a positive, constructive total ministry to patients."

He said it was significant that "the whole program came about through the initiative of the physicians."

### The Volunteer Chaplain

The second step in the overall chaplaincy program, that of providing a qualified minister to serve a weekly tour as hospital chaplain, was undertaken last spring.

"This phase of the program presented more problems than we encountered in setting up vesper services," Mr. Lyles said. "Fortunately, we obtained a great deal of information from the North Carolina Baptist Hospital Department of Pastoral Care, which has pioneered in hospital chaplaincy in the South."

Plans for the program were worked out by the committee during the summer months and presented to the board of trustees and the four ministerial associations for approval.

The board gave its full approval to the program in September and, at the same time 38 ministers of at least 10 denominations agreed to serve as volunteer chaplains. The program was explained to physicians at a weekly staff meeting and received the enthusiastic approval and support of that group.

On October 20, a training workshop for all volunteer chaplains was held at the hospital. The program was conducted by the Rev. Truman Smith, instructor in pastoral care at Southeastern Baptist Seminary at Wake Forest, North Carolina.

More than 70 persons, including physicians, ministers, trustees and administrative personnel attended a dinner meeting that evening. The guest speaker was the Rev. Arthur Backus of Charleston, whose subject was "The Healing Team in the Hospital." His address was followed by a general discussion of the program and the

ways in which the physicians and ministers could work together harmoniously.

The program was begun officially on November 1, with the Rev. Chester McCullough of Nitro serving as the first volunteer chaplain. His weekly tour of duty ended the following Sunday, at which time he conducted vesper services (see photos).

### Chaplain Aided by Auxiliary

The chaplain is aided considerably in his daily work by the Woman's Auxiliary. Members of that organization request each patient admitted to fill out a religious information card. A quick glance at the card gives the chaplain information concerning the patient's religious affiliation, the name of his minister and whether he has been notified of the patient's admittance to the hospital. Also, the patient is asked to state whether he would appreciate a visit from the hospital chaplain.

The chaplain is expected to be in the hospital at 8:30 A.M. and remain there until regular rounds are completed. He is on call 24-hours a day.

The following is a list of the basic duties of the chaplain:

(1) Checks list of new admissions and collects religious information cards upon arrival at the hospital.

(2) Checks with the Auxiliary and sees that notification calls about new admissions are made to local ministers, and cards mailed to those residing outside the Kanawha Valley.

(3) Visits patients who have no church affiliation, those who do not have a local minister, those referred by physicians, and his own members. He does not visit patients who have a local minister unless requested to do so.

(4) Helps where death occurs by immediately informing the local minister and ministering to the family until his arrival.

(5) On call for emergencies at all times during his week's duty.

(6) Keeps an accurate record book. Reports are made to the hospital chaplaincy committee, ministerial associations, hospital staffs and trustees.

(7) Personal counseling with families.

(8) Conducts the Sunday vesper service as his last duty of the week.

All members of the four cooperating associations are eligible to participate in the chaplaincy program. Prior to becoming volunteer chaplains a minister must attend a training workshop and agree to accept full responsibility during the time he is on duty.

### Valuable Assistance Provided by Chaplains

Doctor Spencer said he is sure that the assistance provided by the volunteer chaplains will become "an important and integral part of the overall services offered at Thomas Memorial Hospital."

He said that in many instances the minister is the one person who can instill the necessary courage and hope in the mind of the patient. "I believe the chaplain will be particularly helpful in cases when out-of-town patients are admitted to the hospital," he said. "The presence of a chaplain to visit these patients will in part make up for the absence of the immediate family and friends."

Mr. Lyles said all groups involved in the program are pleased by the progress made in less than two years. "We are still looking to the future," he said, "especially toward completion of the permanent Wohlford Memorial Chapel. Also, along with the chapel, perhaps the future success of the volunteer chaplaincy program will justify employment of a full-time, professionally trained chaplain."

He said the committee also hopes to inaugurate a Sunday school class for the pediatric ward, and possibly a class for adults.

"We hope that other hospitals in the state will establish similar programs," Mr. Lyles said. "Wherever there are interested physicians and ministers, together with a sympathetic and cooperative administrator and board of trustees, a program can be undertaken."

**Active participants in the "Volunteer Chaplaincy Program" at Thomas Memorial Hospital are, left to right, Dr. Tracy N. Spencer, Jr., chairman of the chapel committee; Mrs. Chester McCullough and the Rev. Chester McCullough of Nitro, who conducted the vesper service on Sunday, November 6; Mr. George I. Mattix, hospital administrator; and the Rev. John S. Lyles of Dunbar, chairman of the hospital chaplaincy committee.**

## Dr. Pat Tuckwiller Named by Governor As Member of DPA Advisory Board

Dr. Pat A. Tuckwiller of Charleston has been named by Governor Cecil H. Underwood as a member of the State Advisory Board to the Department of Public Assistance. He was appointed for the term ending June 30, 1966.

Pat A. Tuckwiller, M. D.

The five-member board is bi-partisan and meetings are held quarterly. The board studies and considers legislation and administration concerning public assistance and serves in an advisory capacity to the state director of the DPA.

Besides Doctor Tuckwiller, the board is composed of Mrs. John R. Davis of Weston; Frederick N. McCamick of Wellsburg; John F. Reilly of Morgantown; and N. D. Waugh of Logan.

Doctor Tuckwiller received his M. D. degree in 1929 from the University of Chicago School of Medicine. Previously, he had received a B.S. degree from West Virginia University. He interned at the Presbyterian Hospital in Chicago and served residencies at the City Hospital and Lakeside Hospital in Cleveland, and the Johns Hopkins Hospital, Baltimore.

He has practiced his specialty of internal medicine in Charleston since 1932, being certified by the American Board of Internal Medicine.

Doctor Tuckwiller was chief of staff at Memorial Hospital in Charleston, 1951-54, and chief of internal medicine, 1951-57. He now is a member of that hospital's executive committee. He has been medical consultant to the Charleston General Hospital since 1940 and is immediate past president of the West Virginia Society of Internal Medicine.

He served in the Medical Corps of the Army during World War II and was released with the rank of Colonel.

He is an active member of Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association, and was accepted as a Fellow of the American College of Physicians in 1939.

## Dr. Starkey Accepts Appointment At USC School of Medicine

Dr. A. L. Starkey, former superintendent of Hopemont Sanitarium and assistant professor of medicine at West Virginia University School of Medicine, has accepted appointment as assistant professor of medicine at the University of Southern California School of Medicine in Los Angeles.

Doctor Starkey is also serving as a member of the staff of the VA Hospital in San Fernando, California.

## Fifth PG Institute at Martinsburg Attended by 300 Physicians

More than 300 physicians attended the 5th Annual Potomac-Shenandoah Valley Postgraduate Institute at Martinsburg, October 21-23. The overall registration exceeded 600, including nurses, pharmacists, residents in hospitals, exhibitors and other guests.

Many physicians attending the Institute expressed the opinion that the scientific program was one of the best ever arranged for an annual meeting in Martinsburg.

Dr. Halvard Wanger of Shepherdstown served as general chairman, and the use of a theatre near the headquarters hotel for scientific lectures seemed to meet with general approval. All of the exhibits were set up at the Shenandoah Hotel, and the luncheons, dinners and annual banquet were held there.

The meeting, sponsored by the Eastern Panhandle Medical Society and the West Virginia Chapter of the American Academy of General Practice, provided for 17 hours Category 1 credit to members of the Academy who were present.

Doctor Wanger reported that the 1961 meeting would be held at Martinsburg, October 27-29, with headquarters again at the Shenandoah. He said that the meeting in 1962 will be held the middle of September so as to coincide with the centennial of the Battle of Antietam.

The September dates were selected for 1962 on the theory that many of those attending the meeting would like to have an opportunity to observe some of the staging of the centennial of the battlefield just across the Potomac from Shepherdstown. Doctor Wanger said that the meeting that year would be held as usual in Martinsburg.

### Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly corncerning any change in address. Notices should be mailed to Box 1031, Charleston 24, West Virginia.

## Dr. Andrew K. Butler New President Of W. Va. Radiological Society

Dr. Andrew K. Butler of Wheeling was elected president of the West Virginia Radiological Society at a meeting held at the Lakeview Country Club, near Morgantown, on November 6. He succeeds Dr. John D. H. Wilson of Clarksburg.

Dr. Hubert A. Shaffer of Morgantown was named vice president, and Dr. Karl J. Myers of Philippi was reelected secretary-treasurer.

Dr. Rex Dauphin of Parkersburg was named a member of the executive committee. Hold-over members are Doctor Shaffer and Dr. W. Paul Elkin of Charleston. Dr. Joseph L. Curry of Wheeling was nominated for councillor to the ACR, and Dr. J. Dennis Kugel of Charleston, was named alternate.

## Large Attendance at Eighth Annual Bluefield Sanitarium Seminar

More than 250 persons attended the Eighth Annual Medical Seminar, sponsored by the Bluefield Sanitarium, the Stevens Clinic and the Clinch Valley Clinic, which was held in Bluefield on November 9.

The one-day meeting featured an afternoon scientific session at the Bluefield High School auditorium, and a banquet at the Bluefield Country Club that evening. A social hour preceded the banquet.

The first part of the scientific program was devoted to a "Symposium on Soft Coal Miner's Pneumoconiosis." The speakers were Mr. David Kennedy of Beckley, attorney and councilor for the United Mine Workers of America, and Mr. William Rice, attorney of Harlan, Kentucky.

Following the presentation of several case reports by Dr. Henry F. Warden, Jr., a member of the staff of Bluefield Sanitarium, the program was turned over to Drs. Arthur J. Vorwald of Detroit, Michigan, and Eugene P. Pendergrass of Philadelphia, who participated in a "Discussion of the Problem from the Medical and Medico-Legal and Radiological Aspects."

Doctor Vorwald is professor and chairman of the Department of Industrial Medicine and Hygiene at Wayne State University College of Medicine, and Doctor Pendergrass is professor of radiology at the University of Pennsylvania School of Medicine. He also is immediate past president of the American Cancer Society.

A question and answer period following the formal speaking program was moderated by Dr. S. G. Davidson of Bluefield.

The speaker at the banquet that evening was Mr. Jim Comstock of Richwood, editor and publisher of *The Hillbilly*. His subject was "The Life and Hard Times of a Hillbilly Editor." He was introduced by Dr. E. Lyle Gage.

The chairman of the program committee was Dr. Henry F. Warden, Jr., and Dr. Hampton St. Clair presided at the banquet.

**Mr. Jim Comstock of Richwood, right, was the banquet speaker at the annual Bluefield Sanitarium Seminar held in that city on November 9. He is shown with Dr. Henry F. Warden, Jr., chairman of the program committee.**

## New Officers of Southern Chapter, ACCP

Dr. DeWitt C. Daugherty of Miami, Florida, was elected president of the Southern Chapter of the American College of Chest Physicians during the 17th annual meeting in St. Louis, Missouri, October 30-31.

Other new officers are Dr. Henry R. Hoskins of San Antonio, Texas, first vice president; Dr. Joseph W. Peabody, Jr., of Washington, D. C., second vice president; and Dr. William S. Klein of St. Louis, secretary-treasurer.

## ACP PG Course in New York City

The American College of Physicians will sponsor a postgraduate course in "Mechanisms of Disease" at the Columbia University College of Physicians and Surgeons, Presbyterian Hospital, in New York City, January 16-20. Co-directors of the five-day course are Drs. Alfred P. Fishman and Stanley E. Bradley.

Further information may be obtained by writing to the American College of Physicians, 4200 Pine Street, Philadelphia 4, Pennsylvania.

**A banquet was held at the Bluefield Country Club in connection with the Eighth Annual Medical Seminar sponsored by the Bluefield Sanitarium. Guests included physicians, attorneys and business and industrial leaders. Shown at the banquet are, left to right, Dr. Eugene P. Pendergrass of Philadelphia, Dr. John A. Warden of Bluefield, Mr. William Rice of Harlan, Kentucky, Dr. Wade H. St. Clair of Bluefield, Dr. Bernard S. Clements of Matoaka, and Dr. Arthur J. Vorwald of Detroit, Michigan.**

## Dr. G. M. Lyon Cited for Meritorious Service In Civil Defense

Dr. George M. Lyon, manager of the VA Hospital at Huntington, was presented with the Pfizer Award of Merit at a meeting of the United States Civil Defense Council in Minneapolis on September 22. The citation follows:

> "Be it known that George M. Lyon, M. D., has been cited for meritorious service to the people of the United States and the medical-health professions for his endeavor in the interest of Civil Defense, Disaster Medical Care, Radiological, Biological and Chemical Non-Military Defense and Mass Casualty Care, and in recognition thereof is awarded this Certificate of Merit with Key, established by Charles Pfizer and Company, Inc."

The citation is signed by Philip Klein, President, and E. R. Jackson, Secretary.

The United States Civil Defense Council is an organization composed of city-county civil defense directors. For the past nine years, the council has solicited the assistance of medical-health personnel, presenting a well-rounded program at the annual meeting.

The directors are the leaders and legally constituted heads of civil defense organizations at the local level. Physicians and supporting personnel must work with directors and have an opportunity to counsel with them concerning the many facets of disaster preparedness.

Doctor Lyon served as chairman of the State Medical Association's Committee on Medical Emergencies and Civil Defense, 1958-59. He served in the Medical Corps of the Navy, during World War II, being released with the rank of Captain in 1947. He was presented with the Gold Star in lieu of the 2nd Legion of Merit. Prior to entering the armed services he engaged in the practice of his specialty of pediatrics in Huntington. He was consultant to the Council on National Defense of the AMA, 1947-53. He has served for several years as manager of the VA Hospital in Huntington.

## New Association Members

Dr. Irvin S. Perry, Charleston Memorial Hospital (Kanawha). Doctor Perry, a native of Bristol, Virginia, was graduated from Virginia Military Institute and received his M. D. degree from the Medical College of Virginia in 1955. He interned at Charleston Memorial Hospital, 1955-56, and served residencies at that hospital and at Bowman Gray School of Medicine Hospital, 1956-59. He formerly practiced his specialty of internal medicine at the VA Hospital in Mountain Home, Tennessee.

* * * *

Dr. E. Walter Rice, Martinsburg (Eastern Panhandle). Doctor Rice was born in New Market, Virginia, and was graduated from Bridgewater College. He received his M. D. degree from the Medical College of Virginia in 1944 and served an internship at the Naval Hospital in Portsmouth, Virginia, 1944-45. He served residencies at the Robert Packer Hospital and Guthrie Clinic in Sayre, Pennsylvania, 1957-60. His specialty is radiology.

## Reporting Venereal Disease

Syphilis and gonorrhea have not been brought under control anywhere in the world. In the United States, where intensive efforts to find, treat, and prevent VD have been actively under way since 1936, the Public Health Service estimates that about 60,000 cases of syphilis occur each year. In 1959, only 8,178 new, early contagious cases were reported. Perhaps 1,000,000 or more new cases of gonorrhea occur in the United States each year. In 1959 only 237,318 cases were reported. In this discrepancy between cases occurring and cases reported lies the challenge to the contemporary health worker.—T. LeFoy Richman in Journal, Med. Assn., State of Alabama.

## Wisdom from Experience

We should be careful to get out of an experience only the wisdom that is in it—and stop there; lest we be like a cat that sits down on a hot stove-lid. She will never sit down on a hot stove-lid again—and that is well; but also she will never sit down on a cold one anymore.—Mark Twain.

## Two Physicians Elected To State Legislature

Two physicians will serve in the 1961 Legislature, one in the Senate and the other in the House of Delegates.

Dr. Ward Wylie of Mullens, who has been a member of the Senate continuously since 1945, was reelected in November and will serve another four-year term beginning January 1, 1961.

Dr. Thomas G. Matney of Peterstown was reelected a member of the House of Delegates from Monroe County and will serve another two-year term beginning with the regular session in 1961.

## Dr. Koenigsberg Named to APM Post

Dr. Max Koenigsberg, internist of Charleston, was elected a member of the Executive Committee of the Academy of Psychosomatic Medicine during the annual meeting of that organization in Philadelphia, October 13-15. Doctor Koenigsberg is also chairman of the national membership committee.

## Polio Shots Given 91 Million

New estimates, released by the Public Health Service recently, show that over 91 million persons have now had one or more shots of polio vaccine and 72 million of them have had the three or more shots required for complete vaccination.

The estimates were developed by the National Foundation with data supplied by the Public Health Service and local chapters of the Foundation.

The new figures indicate that 40 per cent of the population now have maximum protection against polio.—Journal, Med. Assn., State of Alabama.

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| Polyphagia | 28 | 25.4 |
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| Lethargy | 14 | 12.7 |
| Enuresis | 7 | 6.4 |
| Vomiting | 5 | 4.5 |
| Irritability | 3 | 2.7 |
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| "Sticky diaper" | 3 | 2.7 |
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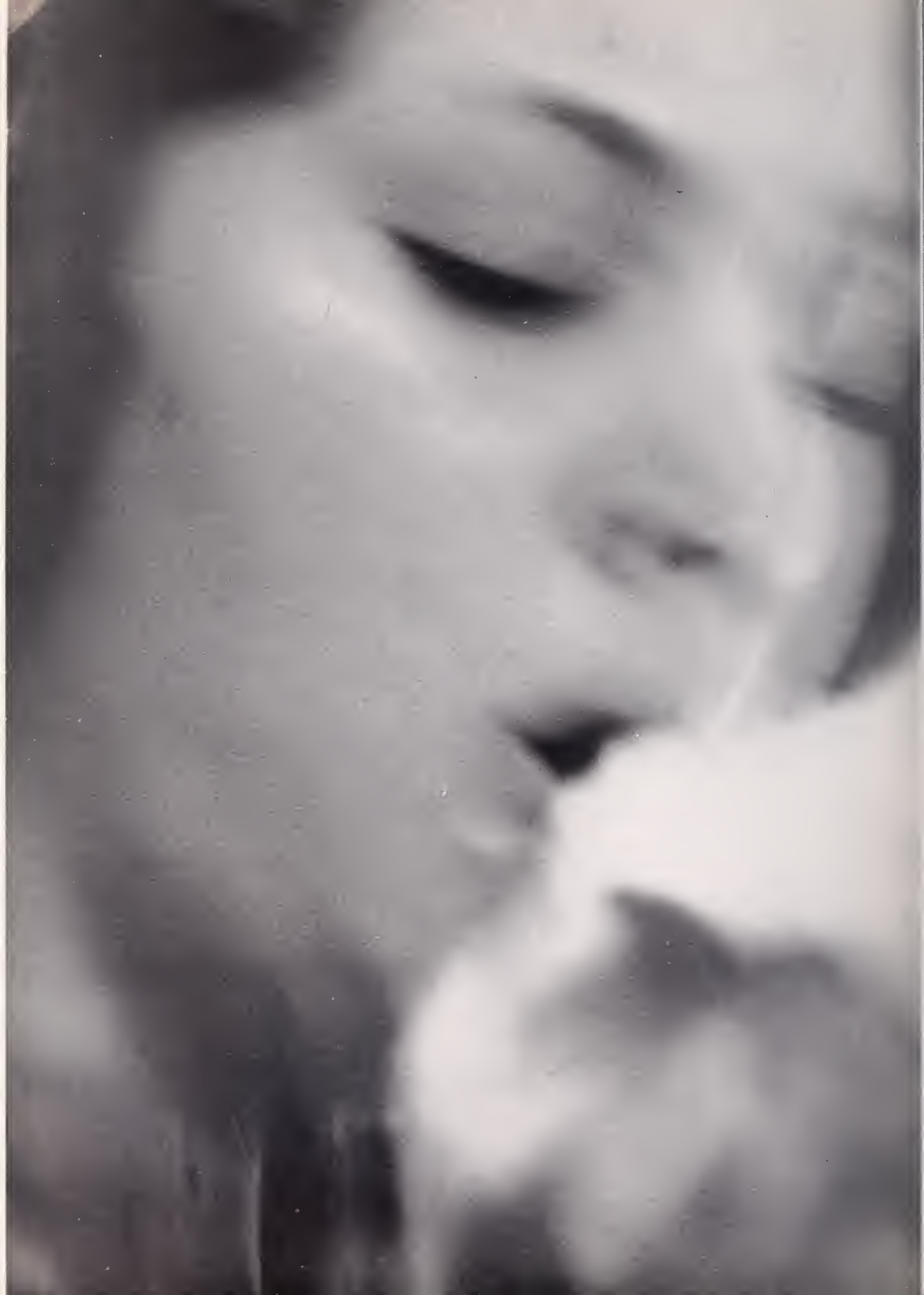

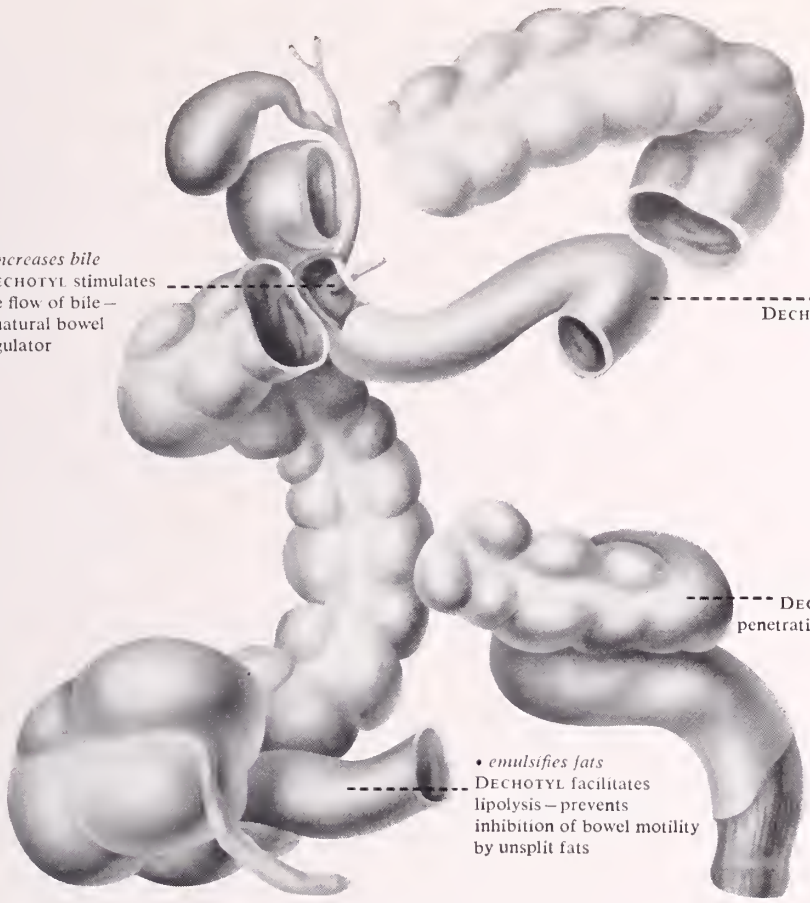


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